October, 1957

MENTAL HYGIENE

Published Quarterly by the
National Association for Mental Health

Quarterly Journal of the

National Association for Mental Health, Inc.

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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

$6.00 a year (Canadian $6.25; foreign $6.50). Single copy $1.50. Publication office: 374 Broadway, Albany 7, N. Y. Editorial and business office: 10 Columbus Circle, New York 19, N. Y. Second class mail privileges authorized at Albany, N. Y.

VOLUME FORTY-ONE, NUMBER FOUR *October, 1957*

Articles

Book Reviews

LENORE KORKES, PH.D.

Physicians' attitudes toward the mental health problem

A survey of information, opinions and attitudes about mental illness of doctors currently practicing in New Jersey was undertaken for the department of research in neurology and psychiatry of the New Jersey Department of Institutions and Agencies.[1] The pre-testing of items, field work and tabulation of findings were executed by Audience Research, Inc., of Princeton, of which George Gallup, Ph.D., is director.

The present report is the result of a statistical evaluation of the data. All responses have been cross-tabulated with the following sociological variables: age, number of years in practice, rural *versus* urban county residence, type of practice (general or specialized) and religious preference.

Chi-square tests have been performed and all the findings presented below related to these five variables have satisfied at least the .05 probability level unless it is otherwise indicated.

There were too few cases of female or colored doctors in the sample to permit of any evaluation of the variables of sex and color.

SELECTION OF RESPONDENTS

The names of the doctors interviewed were selected from lists of doctors (excluding those who specialize in the care or treat-

Dr. Korkes is in the department of research in neurology and psychiatry of the New Jersey Department of Institutions and Agencies.

[1] The questionnaire was constructed by Dr. Robert C. Myers, chief of community mental health services in the Department of Institutions and Agencies. Dr. Myers incorporated into his design suggestions made by Dr. Kenneth E. Appel, president of the Joint Commission on Mental Illness and Mental Health, and Dr. Maurice G. Kott, chief psychologist in the Department of Institutions and Agencies. The survey was sponsored and financed by the department of research in neurology and psychiatry, of which Dr. Nolan D. C. Lewis, is director.

ment of mental illness) who practice in the six counties in which a previous survey of the general public was conducted. Three of these counties—Essex, Hudson and Mercer—are largely urban and the other three—Hunterdon, Salem and Warren—are largely rural. Interviews were obtained with about half the doctors listed in the three rural counties. In each of the urban counties the number of interviews obtained was based on the proportion of the number of doctors in that county to the total number of doctors in the three urban counties. The names of the doctors to be interviewed were selected at random from an alphabetized list of doctors in each county in such a manner that those selected for interviewing should be representative of all doctors in the county. Psychiatrists and neuropsychiatrists were excluded from the sample.

Prior to the interview each doctor was sent a letter signed by Dr. Gallup explaining the nature and purpose of the survey. After a suitable period of time, Audience Research's field interviewers telephoned the doctor's office to arrange a convenient time for the interview. A large majority of the doctors were most cooperative both in granting interviews and answering the questions fully.

The field work took place during October and November 1954.

SAMPLE

A total of 405 doctors participated in the study.

YEARS IN PRACTICE

9% less than 5 years
14% from 5 to less than 10 years
15% from 10 to less than 15 years
62% 15 years or more

TYPE OF PRACTICE

49% general practice
51% specialized practice

AGE

25% from 21 to 39 years old
40% from 40 to 49 years old
35% 50 and over

RELIGIOUS PREFERENCE [2]

37% Protestant
28% Catholic
32% Jewish
3% not classified

SEX

97% male
3% female

COLOR

97% white
3% colored

COUNTY OF RESIDENCE

87% urban
13% rural

GENERAL INFORMATION AND OPINIONS

Over three-quarters of all the doctors included in the present survey did not know how many patients there are in state mental

[2] In the tabulations, Audience Research, Inc., grouped the Jewish and all other non-Protestant and non-Catholic respondents into one category: "all other." Since the Jewish group was 91% of this "all other" category any differentiating attitudes are assumed to reflect correlations with this particular faith.

hospitals; 52% were unable to venture an estimate; 25% considerably under-estimated the number. Only 23% of the total were approximately accurate (*i.e.,* answered 17,000 or over).

The majority (63%) also could not guess even approximately how much money is spent yearly by the state for the care of mental patients. Most of those who did offer an estimate markedly under-estimated the cost to the state.

Only 38% could correctly identify the department responsible for running the state mental hospitals. Knowledge of the correct agency was related to age. We found that only 29% of those under 40 years of age and 42% of those 40 and over correctly named the Department of Institutions and Agencies.

The majority of the doctors did not know anything about the programs of either the Menlo Park Diagnostic Center or the New Jersey Neuro-Psychiatric Institute.

Only 22% were able to provide any information about the program at Menlo Park. Doctors in practice for 15 years or more, and more particularly those over 50, were less likely to be familiar with the services provided. Twenty-nine percent of those in practice less than 15 years and only 17% of those in practice longer than that could give any information. When we break down the sample into three age-groups we find that 25% of those under 40 and 29% of those 40 to 49 but only 11% of those over 50 know anything about the program.

Over one-half of the responding doctors said they had not heard about the reorganization of the State Village for Epileptics at Skillman into the New Jersey Neuro-Psychiatric Institute. The majority of those who said they had heard about the reorganization were not able to provide any further information with regard to the nature of the change.

KNOWLEDGE AND OPINIONS ABOUT RESOURCES

Sixty-seven percent of the total reported that there are facilities in general hospitals nearby to which patients in need of psychiatric care can be referred. The vast majority of those who stated there are no such facilities in their locality would like to see them made available.

Sixty-nine percent reported that they know of a mental hygiene clinic in their community to which they could refer patients. Doctors residing in urban counties are more likely to report the availability of such clinics (73%) than are those in rural counties (40%). Further, specialists are more likely to report knowledge of such facilities (75%) than are those engaged in general practice (62%). However, this latter finding may be related in part to the rural-urban factor, since 79% of the doctors residing in rural counties are general practitioners and only 44% of those in urban counties are in general practice.

One-half of all those who said they know of a mental hygiene clinic in their locality were not able to venture any information about the number of days per week in which clinic service is provided. Forty-two percent of the group who know of a clinic service feel that patients can be seen very or fairly quickly. Twenty-nine percent stated there is a long waiting list; 29% did not know how long a patient would have to wait.

Doctors who said they know of a local mental hygiene clinic were asked their opinion of the service. Thirty-two percent hold a completely favorable opinion of the local clinic. Thirty-four percent have some qualification in their opinion, for the most

part in terms of a quantitative factor (*i.e.*, shortage of staff, long waiting list, too little service time available). Only 5% have an unfavorable opinion of the local clinic facility. The remaining 28% responded that they did not know enough about it to voice an opinion. We found that the older doctors were more likely to offer an unreservedly favorable opinion and the younger physicians were more likely to have some criticism to offer. Only 18% of those under 39 years but 32% of those in the 40 to 49 age-range and 41% of those 50 years of age and older offered an unqualified favorable opinion. Significant differences were also noted in the closely related variable of years in practice. The findings are summarized in the table.

All physicians who reported knowledge of a local mental hygiene clinic were also asked, "How would you say it could be improved?" Thirty-seven percent replied in terms of increasing the quantity of services (including more financing); 8% answered in terms of increasing the quality of available services; 7% said they thought referral agencies need to be better informed about the use of the clinic; 6% gave other suggestions including more emphasis on treatment in addition to diagnosis. Fully 42% of all those asked this question could offer no suggestions for improving the clinic service. Older doctors were more likely to fall into this last category. We found that only 30% of those under 40 but 39% of those from 40 to 49 years and 55% of those 50 years of age and older did not offer suggestions for improving the local mental hygiene service.

All doctors were later asked the general question, "How would you say psychiatry and psychiatrists could be improved and made of more service to you and your patients?" The answer most frequently given was in terms of increasing the quantity of service available with particular emphasis upon lowered costs. Forty-five percent of the total answered this question by saying that more psychiatric service, including clinics, need to be made available at less cost to patients or that ways should be found to shorten the treatment time.

Physicians' opinions of local mental hygiene clinic services, classified by the physicians' ages and years in practice

	UNQUALIFIED FAVORABLE OPINION *(percent)*	QUALIFIED OPINION *(percent)*	UNQUALIFIED UNFAVORABLE OPINION *(percent)*	NO OPINION DON'T KNOW *(percent)*
AGE				
21–39 years	18	42	8	32
40–49 years	32	38	6	24
50 years and older	41	23	3	33
YEARS IN PRACTICE				
0–15 years	23	39	6	32
15 years or more	37	31	5	27

* Based only on those who reported they know of such a service. N = 283.

Younger physicians were more likely to emphasize this factor: 51% of those under 50 but only 37% of those over 50 years of age gave this kind of response. The religious preference is also correlated with the frequency of this answer. Only 36% of the Protestants but 42% of the Catholics and 60% of the "all other" group (91% of the latter are of the Jewish faith) referred to the need for more service at less cost.

Twenty-one percent of the total felt that psychiatric service could be improved by having more psychiatrists available (without reference to lowered costs); 9% felt that more diagnostic facilities and clinics are needed; 8% felt that there is a need to increase the education of the public to eliminate prejudice about going to a psychiatrist; 7% mentioned the need for more cooperation between psychiatrists and general practitioners.

Eleven percent of the total sample could not offer a suggestion for improving psychiatric service to themselves and their patients. Doctors who were specialists were somewhat more likely to answer "don't know" to this question (15%) than were general practitioners (6.5%). Also doctors over 50 years of age were more likely to have no suggestion (17%) than those in the 40 to 49 year group (8%) or the under-40 group (7%).

When asked directly, "Would you like to see more psychiatric facilities or clinics made available in your community?" 71% of the total sample responded yes. Twenty-two percent said no and the remaining 7% said they did not know whether or not they would. Younger physicians were more likely than older doctors to answer this question in the affirmative. Seventy-nine percent of those under 40 years of age, 73% of those from 40 to 49 years and only 62% of those 50 years of age and older said they would like to see more psychiatric facilities in their community. General practitioners were somewhat more likely to say they definitely would like to see more of such facilities (76%) than were medical specialists (67%). We may also note that of all the religious groups Protestants were less likely to answer in the affirmative (59%) than Catholics (77%) or "all other" (78%). The most frequently given reasons for wanting more facilities were that more psychiatric help is needed to cope with the existing problems (36%) and/or that more clinic service is needed for those unable to pay regular psychiatric fees (29%).

Sixty-seven percent of the total reported that there are facilities in one or more general hospitals nearby to which patients in need of psychiatric care might be referred. Twenty-eight percent reported there are no such facilities; over three-fourths of these would like to see them made available. Five percent of the total said they did not know whether or not there were any psychiatric facilities in general hospitals nearby.

The majority of the doctors included in this survey (58%) answered no to the question, "In general, do you think New Jersey's state mental hospitals are able to handle the job that needs to be done for the mentally ill?" Only one-fourth felt that the state mental hospitals are adequate for the task; 17% could not answer this question. Again we found evidence of a more critical attitude among younger doctors. Sixty-seven percent of those under 40 years of age, 61% of those in the 40 to 49 year range but only 46% of the physicians 50 years old or more felt that the state hospitals at present are not able to deal with the problem of the mentally ill in an adequate manner. We also found a similar result when we compared the closely related variable of numbers of years

in practice: 67% of the doctors in practice less than 15 years but only 52% of those in practice more than 15 years answered no to this question. Finally we may note that the incidence of the "don't know" response increased with age in this question as well as many others.

ATTITUDES TOWARD THE PSYCHIATRIC PROFESSION

All doctors were presented with the following list and asked, "Frankly, Doctor, which of these statements best reflects your own personal feelings about psychiatry as a medical specialty?"

STATEMENT	PERCENT AGREEING
It's a great deal of help	59
It's of some help	38
It's a racket	1
It's mostly nonsense	1
It's an unnecessary refinement	.05
Refused to answer	1

As may be noted, 59% agreed with the statement that psychiatry as a medical specialty is a great deal of help. We find that specialists as a group were somewhat more likely to have this strong positive attitude toward psychiatry (63%) than were general practitioners (54%).

Respondents were further asked why they feel the way they do about psychiatry. Fifty percent said they believed it to be a necessary specialty for all types of mental disorder. Twenty-six percent said they felt it a useful specialty for some mental disorders. Among the negative attitudes most frequently mentioned were that the usefulness of psychiatry is limited by the long-term nature of the treatment and/or its expensiveness (7%) and that the training, competence, integrity or personality of some individuals practicing psychiatry is questionable (6% of the total).

Ninety-four percent of the total sample said that they know one or more psychiatrists personally. All of those who reported that they do were also asked, "Are they pretty able men as compared with other specialists you know?" Over four-fifths held unqualified positive opinions of the psychiatrists they know. Only 4% had an unqualified negative opinion of the psychiatrists they know. The remainder had reservations in their responses—*e.g.*, some are able, some are not (6%); the techniques of the profession itself are inexact (2%); personality characteristics of known psychiatrists undesirable (2%).

INTEREST IN PSYCHIATRY

All doctors were asked, "Do you have a chance to do any reading about psychiatry? About how much would you say—quite a bit, a little, or almost none?" Only 18% replied they do quite a bit of reading about psychiatric matters. Fifty-two percent said they do a little, while 30% said they do almost none or none. Responses to this question are related to age; the data are summarized below:

Amount of reading done by physicians about psychiatry

AGE	QUITE A BIT *(percent)*	A LITTLE *(percent)*	ALMOST NONE OR NONE *(percent)*
21–39 years	17	63	20
40–49 years	19	50	31
50 years and older	18	44	38

We may note that older doctors reported more frequently than did younger physicians that they do no or almost no reading about psychiatry.

There are some trends which just fail to reach our accepted significance level of .05 which might be noted here. Specialists more often than general practitioners reported they do no or almost no reading in psychiatry (35% *vs.* 25%). Also, doctors in urban counties more often reported they do quite a bit of reading (20%) than did rural physicians (8%).

As a further measure of interest in psychiatry, the question "Would you like, for your own information, a down-to-earth popular pamphlet on psychiatry?" was asked. Sixty-eight percent of the total sample replied that they would; 7% said maybe and one-fourth said they would not want such a pamphlet. Doctors engaged in general practice were more likely to say they would like such a pamphlet (78%) than were medical specialists (57%). Also, we found that fewer Protestants said they would like such a pamphlet than did persons with other religious preferences. Thus, 60% of the Protestants, 71% of the "all other group" (91% of whom were Jewish) and 76% of the Catholics said they would like this kind of "popular" pamphlet.

Forty percent of the total said they would definitely attend an extension seminar in psychiatry if one were offered nearby. Another 14% said maybe they would and 46% said they probably would not attend such a seminar. Younger doctors and also those engaged in general practice were more likely than were older doctors and those practicing a specialty to say that they would attend such a seminar. The responses to the question "If an extension seminar in psychiatry were offered nearby, would you attend if you could?" are summarized in column 2:

Percentage of physicians who would attend an extension seminar in psychiatry if one were offered nearby, classified by the physicians' age and type of practice

	YES, DEFINITELY *(percent)*	MAYBE *(percent)*	PROBABLY NOT *(percent)*
AGE			
21–39 years	47	14	39
40–49 years	42	16	42
50 years and older	32	12	56
TYPE OF PRACTICE			
General	51	15	34
Specialized	29	15	56

All doctors were also asked, "Would you like to see more psychiatrists on county medical society programs?" Forty-one percent said yes they would, but 37% said they would not want to see more psychiatrists on such programs. The remaining respondents either said it would depend on which psychiatrists were on the programs (10%) or were uncertain (12%). Comparing those who gave an unqualified affirmative answer with all others, we found that age was once again a pertinent variable in the response. While only 31% of those 50 and over said they definitely would like to have more psychiatrists on county medical society programs, 49% of those in the age-range 40 to 49, and 44% of those under 40 years of age so reported. We also found a difference in the variable of religious preference. Only 30% of the Protestants, 44% of the predominantly Jewish "all other" group, and 53% of the Catholic physicians said they would like to see more psychiatrists included in such programs.

EXPERIENCE WITH PSYCHIATRIC ILLNESS

Several questions in this survey elicited information about the amount of experience a doctor had had in dealing with psychiatric illness.

Only 6% of the total sample reported that their practice is connected in some way with a public or private mental hospital or sanitarium.

Sixty-five percent of the total group reported that they had visited one of New Jersey's mental hospitals. The reason most frequent given for visiting was that the doctor wished to learn about the condition of a particular patient, but not, however, to treat the patient professionally (mentioned by 22% of all those who had visited a mental hospital). Only 9% of the doctors who had visited went in a professional capacity, to treat or give treatment advice about a patient.

Older doctors, and also doctors residing in urban counties, were most likely to have visited a mental hospital. One-half of those in practice for less than 15 years but 73% of those in practice for a longer period had visited one or more mental hospitals. We found that only 42% of doctors in rural counties as against 68% of those in urban counties had visited one or more of New Jersey's mental institutions.

We may note that the majority of those who had visited one of the mental hospitals had done so more than three years before the interview. Only 26% of the total sample (and 39% of those who said they had been to such institutions) had had this experience within the three years immediately preceding the survey. Twenty-eight percent of those who had visited reported this occurred from three to ten years before, and 34% said their last visit was over ten years before, or they did not know exactly when it took place. Although we have just noted that older doctors were more likely to have visited at all than were younger ones, we found that the younger doctors were more likely to have visited during the three years immediately preceding the survey. Thus, whether we examined the age-distribution or the number of years in practice, we found a steadily decreasing percentage of those who had had relatively recent contact with a mental hospital. Taking as a base only those respondents who had visited, we found that 53% of those in practice from zero to 14 years, but only 33% of those in practice for 15 years or more had for one reason or another visited a mental hospital within the three years immediately preceding the interview.

Another measure of experience with psychiatric illness was to be found in the doctor's involvement in commitment procedures. Seventy-eight percent of the total had been involved in committing patients to mental hospitals. We found that only 6% of those in rural counties but 22% of those in urban areas had never been involved in commitments to psychiatric hospitals. Younger doctors were less likely to have been involved in commitments: 29% of those under 39, 21% of those from 40 to 49, and only 16% of those 50 and over reported they had never participated in a commitment procedure. This last finding may be a somewhat simple function of time and experience.

Doctors were also asked, "In committing patients to mental hospitals, do you sometimes use a psychiatrist as the other committing physician? How much of the time?" Forty-four percent of the total said they always did so. Only 10% of the doc-

tors in rural counties but 42% of those in urban counties said they always used a psychiatrist in commitments. Twelve percent of the total said they usually used a psychiatrist in such procedures; 11% said they only occasionally did; 12% said they never did so.

To obtain a general assessment of the frequency with which doctors refer patients for psychiatric care, all respondents were asked, "In your practice, have you found it useful to refer patients to a psychiatrist? About how often would you say?" Four alternatives were provided. Sixteen percent said they often referred patients to a psychiatrist; 67% reported they occasionally referred patients; 12% said they almost never made such referrals; 5% said they never did so. Medical specialists (24%) were somewhat more likely than were general practitioners (11%) to report that they never or almost never found it useful to refer patients to a psychiatrist.

To obtain some measure of personal experience with mental disorder, this question was asked: "Has any member of your family ever suffered from nervous or mental illness?" Twenty-four percent of the total replied yes. These doctors were also queried as to whether or not the patient recovered. The majority reported that the ill family member did indeed recover. Nine percent of the total sample (and 39% of those reporting such an illness in the family) said, however, that the family member had not recovered from the mental illness.

PERCEPTION OF THE EXTENT OF PSYCHIATRIC PROBLEMS IN OWN PRACTICE

A number of questions were posed which either directly or indirectly offered data about the doctors' perceptions of the extent of psychological disturbance encountered within their own practices. One such question was: "About what percentage of your patients would you guess could benefit from the services of a psychiatrist?" The modal answer, given by 58% of the total, was from 1% to less than 10%. Only 3% replied that no one of their patients could use psychiatric help. Fully one-fifth said that from 10% to 29% of their patients would benefit from such help. Six percent were unable to give any answer to this query. The responses were related to age and number of years in practice, and also to religious preference. The data are summarized below:

Physicians' estimates of percentage of patients who could benefit from psychiatric services, classified by the physicians' ages, years in practice and religious preference

	UNDER 10%	10%–49%	50% OR MORE
AGE			
21–29 years	52	35	13
30–49 years	65	26	9
50 years and older	76	15	9
YEARS IN PRACTICE			
0–14 years	56	33	11
15 years or more	71	19	10
RELIGIOUS PREFERENCE			
Protestant	74	20	6
Catholic	66	23	11
All other			
(91% Jewish)	56	31	13
Total	65	25	10

• Excludes those who replied "don't know."

Thus we note that younger doctors were more likely to perceive a higher frequency of psychiatric disturbance among their patients than were older doctors. Further more, Jewish respondents were most likely to report a relatively high incidence of emotional or mental disorder among their patients than were other respondents. Catholic doctors were somewhat less likely to, and Protestant physicians were least likely to note such disorder in more than 10% of their patients.

The following closely related question was also asked, "About what percentage of your patients would you say suffer from a neurosis of any kind—even though they may be suffering from something else as well?" This question seemed to evoke judgments of emotional disturbance which, although subsumed under the concept of "neurosis," may not seem severe enough to indicate the need for psychiatric referral. This inference was made because the doctors interviewed reported a higher percentage of patients with neuroses than of patients "who could benefit from the services of a psychiatrist." Just what criteria were used by the respondents in making this apparent distinction between "neurotics" and "persons who could benefit from psychiatric care" are not known from the data but would certainly be of interest.

We found less than 1% of the total said that none of their patients had a neurosis. Seventeen percent said from 1% to 9% of their patients had a neurosis. Thirty percent said that from 10% to 29% of their patients were suffering from a neurosis. The majority reported that 30% or more of their patients were neurotic. Almost a third of the total stated that over one-half of their patients had a neurosis.

Perceptions of the extent of neuroses among their patients were related to age, number of years in practice, and the type of practice in which the doctors were engaged. Again we found that younger physicians were more likely than were older doctors to perceive a relatively high incidence of neurosis among their patients. Excluding the 7% who could not or did not answer this question, we found that 89% of those in the 21 to 39 year range, 85% of those from 40 to 49 years, but only 71% of those 50 years of age or older noted that 10% or more of their patients "suffer from a neurosis of any kind." We also found that general practitioners were somewhat more likely to note neuroses among their patients than were medical specialists: 86% of those in general practice, 76% of the specialists, reported that 10% or more of their patients suffered from a neurosis.

A third measure was employed to gauge further the extent of psychological disorder as estimated by doctors in their practice: "Do you see much psychosomatic disease? How much?" Three alternative responses were given: a good deal, some, and not much. Unfortunately, we cannot know just how each respondent interpreted these categories. Thus "a good deal" might have meant quite different percentages of patients to different doctors. Keeping in mind this limitation on the usefulness of the data, we may note that 45% of the total sample reported they saw a good deal of psychosomatic disease, and another 32% said they met up with some psychosomatic disease. Only 23% reported they did not see much of such disorders among their patients. Responses to this question varied significantly with each of the five major background variables included in the analysis. The table below summarizes these data:

Physicians' estimate of amount of psychosomatic disease seen, classified by the physicians' ages, years in practice, type of practice, type of county of residence and religious preference

	A GOOD DEAL (percent)	SOME (percent)	NOT MUCH (percent)
AGE			
21–39 years	49	38	13
40–49 years	48	30	22
50 years and older	41	29	30
YEARS IN PRACTICE			
0–14 years	46	39	15
15 years or more	45	27	28
TYPE OF PRACTICE			
General	54	28	18
Specialized	38	35	27
TYPE OF COUNTY OF RESIDENCE			
Rural	60	13	27
Urban	43	34	22
RELIGIOUS PREFERENCE			
Protestant	38	34	28
Catholic	41	34	25
All other (91% Jewish)	56	28	16
Total	45	32	23

We may note that younger doctors, general practitioners and rural physicians were most likely to see "a good deal" of psychosomatic disease among their patients. Also, Jewish physicians were more likely to note "a good deal" of such disease than were doctors with other religious persuasions.

Two other questions in this survey may perhaps be regarded as crude indices of psychological disorder among the patients of the doctors in the sample. They both deal with the relationship between presenting complaints and the presence of adequate physiological cause. One of these questions was, "About what percentage of people that you have recently seen as patients seem to have complaints for which you are unable to find adequate cause?" Only 7% said none, 37% said from 1% to 9%, 31% said from 10% to 29%, 9% said from 30% to 49%, 9% said 50% or more and 7% said they did not know.

Younger doctors were much more likely to report a relatively high percentage of cases for which they found no adequate cause. The data are summarized as follows:

Physicians' estimate of percentage of patients with complaints for which doctor can find no adequate cause, classified by the age of the physicians *

	NONE	1%–9%	10%–29%	30% OR MORE
AGE				
21–39 years	8	30	37	25
40–49 years	6	36	40	18
50 years and older	10	51	23	16
Total	8	39	33	20

* Excludes those who replied "don't know."

Almost the reverse form of the above question was also asked, "About what percentage of your patients do you feel have definite organic or physiological pathology?" Twenty-eight percent of the total replied that less than 70% of their patients could be so described. Sixty percent said that over 70% of their patients presented definite organic pathology, and 12% said

they did not know. Doctors over 50 years of age were more likely to say they didn't know (20%) than were those under 50 (9%). Specialists were somewhat more likely to note a high incidence of definite pathology (74% of all giving a definite estimate said that over 70% of their patients may be so described) than were general practitioners (61%).

OPINION OF OWN COMPETENCE IN HANDLING PSYCHIATRIC DISORDERS

The vast majority of the physicians in this survey (88%) said that they felt able to make a differential diagnosis between psychoses and neuroses. Seventy-six percent of the total gave an unqualified affirmative answer to the question "Do you feel you are able to distinguish between psychoses and neuroses?" General practitioners were somewhat more likely to feel they are able to make such a differential diagnosis (94%) than were specialists (84%). Also, of the three religious groups, Protestants felt somewhat less able (82%) to make such differential diagnoses than did Catholic (93%) or "all other" (94%) respondents.

All doctors who replied yes to the above query were then asked, "In general, do you feel able to treat a neurosis?" Fifty-seven percent of the total sample (and 65% of all those who said they could distinguish between neuroses and psychoses) said yes, they did feel able to treat neurosis. Only 12% of the total flatly said no. The remainder gave various qualified responses. Opinions of their own competence were related to age, number of years in practice and type of practice. The table in column 2 sums up the data.

It may be seen that older doctors were more likely to feel that they were able to treat a neurosis, and that younger doctors were more likely to have some qualified opinion of their own competence to do so. Furthermore, general practitioners were more likely to believe that they were able to treat such a disorder than were medical specialists.

Physicians' estimate of own ability to treat a neurosis, classified by the physicians' age, years in practice and type of practice *

	YES *(percent)*	NO *(percent)*	OTHER *(percent)*
AGE			
21–39 years	61	9	30
40–49 years	61	17	22
50 years and older	72	15	13
YEARS IN PRACTICE			
0–14 years	59	12	29
15 years or more	68	15	16
TYPE OF PRACTICE			
General	72	7	21
Specialized	57	21	22
Total	65	14	21

* Based only on those who said they felt able to distinguish between psychoses and neuroses. N = 355.

All doctors were later asked, "Do you feel comfortable in treating so-called psychosomatic disorders?" Of the total, 53% said yes, 17% said "it depends," 27% said no and 3% said they never treat psychosomatic disorders.

Thus a majority of the doctors felt able to treat psychosomatic disorders. General practitioners were once again more likely to feel competent than were specialists; 62% of the former replied yes to this question in contrast with only 45% of the medical specialists.

CONCEPTIONS OF MENTAL ILLNESS

All respondents were asked, "What do you think are the three most common causes of mental illness?" Their responses were coded as follows:

Physicians' opinions of most common causes of mental illness

	PERCENT OF TOTAL
Anxiety regarding health or stress of modern living	65
Family or marital or sexual tensions	39
Inherited predisposition	30
Other responses regarding factors productive of anxiety or emotional maladjustment	30
Physical injury, illness, rundown or aged physical condition	27
Emotional deprivation or improper parental guidance during maturation	18
Don't know	8

Each of these responses was checked against the major sociological variables in the analysis. The results were as follows:

Years in practice and age. The frequency of responses assigning etiological significance to the factor of emotional deprivation or improper parental guidance during maturation decreases with increasing age or number of years in practice. Thus, 29% of those under 40, 17% of those from 40 to 49 years and only 11% of those 50 years of age or more mentioned this factor as one of the three most common causes of mental disorders.

It might also be noted here that older doctors were somewhat more likely to be unable to give any response to this question. Only 3% of those in practice less than 15 years but 10% of those in practice for a longer period said they did not know what might cause mental disorder.

Type of practice. General practitioners were more likely to mention anxiety about health or the stress of modern living as a causative factor in mental illness (73% did so) than were medical specialists (59%). Doctors in general practice were also more likely to refer to physical injury, illness, run-down condition, or aging as a cause of mental disorder (33%) than were the specialists (21%).

Religious preference. The only significant trend observed here was that more Jewish physicians mentioned the factors of family or marital or sexual tensions as a common causative factor in mental illness (approximately 49% did so) than did the Protestant and Catholic doctors (34% in each of the two groups did so).

Inclusiveness of the concept of mental illness. Doctors were asked whether or not they would classify the following disorders under the term mental illness (here presented with the distribution of response):

Percentage of physicians classifying selected disorders as mental illnesses

	YES *(percent)*	NO *(percent)*	IT DEPENDS AND DON'T KNOW *(percent)*
Mental deficiency	62	28	10
Feeblemindedness	62	31	7
Paresis	57	34	9
Epilepsy	21	67	12
Cerebral palsy	17	73	10
Parkinsonism	11	82	7
Multiple sclerosis	8	85	7

That so many doctors viewed such disorders as mental deficiency, paresis and epilepsy as mental illness may have resulted in part from the fact that certain textbooks in psychiatry include these disturbances alongside the discussions of neuroses and psychoses. It is difficult to know from the present data whether or not a respondent was following a textbook organization or was rather stating his own delineation of the concept of mental illness.

We may note that the inclusion of particular disorders under the rubric of mental illness varied with the physician's age, type of practice and religious preference.

Age and years of practice. Older doctors were more likely to consider epilepsy as a mental illness (28% of those 50 years and over did so) than were younger ones (19% of those from 40 to 49 years; 13% of those under 40 years). This same trend was noted in relation to the number of years in practice.

Also, doctors 50 years of age or over were more likely to classify feebleminded-ness as a mental illness (70% did so) than were those under 50 (57%).

Type of practice. General practitioners were more likely to consider epilepsy as a mental illness (25%) than were specialists (16%).

Doctors in general practice also somewhat more frequently included mental deficiency in their conception of mental illness (67%) than did specialists (57%).

Religious preference. Doctors whose religious preference was Protestant were somewhat more likely to consider feeble-mindedness as a mental illness (70% did so) than were Catholics (58%) and the predominantly Jewish "all other" category (56%).

Such a disorder as cerebral palsy was less likely to be considered as a mental illness by Jewish doctors (approximately 9%) than by Catholics (21%) and Protestants (22%).

Finally, doctors of Jewish religious preference were less likely to view paresis as a mental illness (about 47% did so) than were Catholics (64%) and Protestants (63%).

Opinions about treatment methods for mental illness. All doctors were asked the open-ended question, "Briefly what do you think are the best specific methods of treatment of mental disorders?" Unfortunately, the data were not coded so as to permit of distinctions, if they were made, between methods for treating various forms of mental disorder. Nevertheless, it is of interest to note the following findings:

Physicians' opinions of the best methods of treating mental disorders *

METHOD	PERCENT RESPONDING
Shock therapy	32
Psychoanalytic techniques	26
Hospitalization	20
Need for psychiatric help in treatment or diagnosis, without specifying technique	28
Not qualified to say, or don't know	15

* Some doctors gave more than one answer.

Other responses included sedation (mentioned by 6%), occupational or social therapy (6%) and brain surgery (2%).

Younger doctors were more likely than were older doctors to mention psychoanalytic techniques as among the best specific therapies. Thirty-nine percent of those under 40 did so, in contrast with 26% of those between 40 and 49 years and only 16% of those 50 years of age or older.

It may be noted that doctors in general practice were more likely to mention hospitalization or institutionalization as one of the best methods of treatment (25% did so) than were specialists (15%). On the other hand, a somewhat greater proportion of specialists (19%) replied that they were not qualified to say, or did not know, the best treatment methods than did general practitioners (10%).

Estimates of efficacy of treatment of mental disorders. To assess attitudes toward the general effectiveness of psychiatric treatment, the following question was asked, "What results have you seen from the treatment of patients by psychiatrists—for psychosis? for neurosis?" All responses were immediately categorized as either good, fair, poor or don't know. The data are as follows:

Physicians' opinions of the efficacy of psychiatric treatment

	PSYCHOSIS *(percent)*	NEUROSIS *(percent)*
Good	34	41
Fair	39	41
Poor	15	8
Don't know	12	10

There was only a small difference in the percentages for the different categories given for neurosis and psychosis; doctors tended to view the results from treatment for neurosis as slightly better than those obtained in the treatment for psychosis. Here again it would seem important to know more about the criteria used; doctors may use different scales for judging results in the two disorders.

Older doctors were more likely to feel that the results of treatment for psychosis were good, and younger doctors were more likely to describe what they had seen as poor; thus, 26% of those under 40, 18% of those from 40 to 49, and only 8% of those 50 years of age or over said it was their opinion that the results from treatment for psychosis were poor. (These last percentages were based only on those who gave some definite answer.)

DISCUSSION

Influence of age. The younger the physician the more likely he is to have a concerned and critical attiude toward the mental health problem. An older doctor is more likely to offer blanket approval of the local mental hygiene clinic and less likely to have any suggestions for improving its service or indeed for improving psychiatric facilities in general.

The younger doctor tends to have more ideas about the nature and adequacy of currently available resources for coping with mental disorders. In particular, he places more emphasis on the need for more services at less cost to the patient. The younger doctor also more frequently feels that the state mental hospitals are not able to handle the job. It might be noted here that he is also more likely to be informed about the nature of the program of a rather well-publicized diagnostic center.

The older the physician the less likely is he to want to see an increase in psychiatric services in general. Finally, it might be pointed out that there is a general trend for the older doctors to respond "don't know" or to have no opinion on such questions as these.

These findings suggest that the older doctors are comparatively disinterested or even complacent about the mental health situation. Consonant with this interpreta-

tion is the further finding that the older doctors are more likely to report that they do no or almost no reading about psychiatric problems. They are also less likely to express interest in an extension seminar in psychiatry (if one were to be offered) or in having more psychiatrists appear on county medical society programs.

In this connection it is of interest to note that the younger physicians are more likely to report a relatively high incidence of emotional disturbance and psychosomatic disease among their patients. Since the younger doctors tend to be more concerned with the general problem of mental illness, and read more about it, it is perhaps not too surprising to find that they are more ready to recognize it. (The validity of such recognitions are, of course, untested in this study.)

The younger doctor more frequently emphasizes the factor of emotional deprivation or improper parental guidance during maturation as a common etiological agent in mental disorder and, consistent with this, is more likely to endorse psychoanalytic techniques as among the best treatment methods.

The older doctors are somewhat more likely to state that they feel competent to distinguish between neurosis and psychosis, and the younger doctors are more likely to qualify their estimates of their own ability to make such a differential diagnosis. It is in the oldest age group, however, that we find the greatest number of respondents who are unable to offer any idea about the causes of mental illness.

A somewhat less differentiated concept of "mental illness" is held by the older doctor, *i.e.*, he more frequently includes epilepsy and feeblemindedness in his definition of the term.

Finally, we may note that the younger doctors are more likely to judge the results of treatment of psychotics by psychiatrists as "poor."

In sum, a rather consistent trend emerges for the younger physicians to be more concerned with and sophisticated about psychiatric problems. This may be related in part to the fact that the emphasis on psychiatry in medical schools is relatively recent. A companion study to the present one indicated that age is significantly related to sophistication in this area among the general public also. Hence, it may be that the findings are partially attributable to changes in the whole climate of opinion about mental illness over the last several decades. Physicians, too, are members of the public.

Type of practice. Medical specialists, although somewhat more likely to say that they know of mental hygiene clinics in their community, tend to be less able to offer suggestions for improving the available psychiatric services than are doctors engaged in general practice. More of the latter would like to see new clinics made available for referrals.

Specialists are somewhat more likely than are general practitioners to endorse the statement that psychiatry is "a great deal of help." This may perhaps be related to the common status of medical "specialist" shared with the psychiatrist.

Compared to specialists, physicians in general practice would seem to be more interested in acquiring new learning about neuropsychiatric problems. For example, they more frequently say that they would like to have an informative pamphlet, and that they would attend an extension seminar on psychiatry.

We may note that the doctor in general practice is more likely than is the specialist to report that a greater proportion of his patients suffer from neurosis and/or psy-

chosomatic disease, and also that he often finds it useful to refer patients for psychiatric care.

Fewer specialists than doctors in general practice feel competent to make differential diagnoses in mental disorder. (The difference, however, is slight and the vast majority of specialists do feel competent.) Specialists are less likely to feel able to treat either neuroses or psychosomatic complaints. Finally, they somewhat more frequently feel unable or unqualified to offer an opinion on the best methods of treatment of mental disorders than do the general practitioners.

The doctor in general practice more frequently describes hospitalization as one of the best methods of treatment for mental disorder. He is also more likely to view epilepsy and mental deficiency as examples of mental illness.

Possible rationales for some of these observed distinctions are:

• The general practitioners' more frequent perception of emotional or mental disorder among their patients may result in part from the likelihood that most patients, including those whose complaints are largely psychological, would usually first consult a general practitioner. If the doctor finds little or no organic basis, he may not ever refer the patient to a (non-psychiatrist) medical specialist. If there may actually be more neuropsychiatric problems coming to the general practitioner, this might also partially explain his greater concern for the adequacy of the community mental health services.

• The relatively lower interest in new learning about psychiatry among specialists may be related in part to the rather obvious fact that they have already decided to concentrate their knowledge in one area (by definition). Considering this, a sizable percentage of the specialists appear to be concerned about adding to their knowledge of psychiatry. Furthermore, *as* specialists, they may be more likely to regard mental disorder as within the special province of the psychiatric specialty.

• The more widespread feeling of competence in diagnosing and treating mental disorders among general practitioners may be related in part to the possibility that they tend to perceive their roles as encompassing *all* illnesses, at least at certain stages.

Religion. A rather consistent trend emerges when the data are cross-tabulated for religious preference. Protestant doctors appear to be less concerned about the mental health problem than do doctors of other faiths. Since this was also more true of older doctors than of younger ones, the two variables of age and religion were cross-tabulated; perhaps some bias in the selection of the sample had produced this result. We found, however, that religious preference is quite independent of age.

Among the specific findings, we may note that Protestants are the least likely of all religious groups to state that they would like to see more psychiatric facilities or clinics made available in their communities. They are the least likely to note the need for more psychiatric services at less cost; Catholic doctors more frequently, and Jewish doctors most frequently, stress this need.

Protestants are less likely to want an informative pamphlet about psychiatry than are Jews and Catholics. Also, Protestants are less likely to want to see more psychiatrists on county medical society programs than are Jewish and especially Catholic doctors.

Jewish physicians are most likely to re-

port that they encounter "a good deal" of psychosomatic disease among their patients. They also more frequently recognize patients who could "benefit from psychiatric care"; Catholics somewhat less frequently and Protestants least of all report that a relatively high proportion of their patients could so benefit.

It might be noted that Protestant doctors feel somewhat less able to make the differential diagnosis between neurosis and psychosis than do non-Protestants. The Protestant group is also most apt to include feeblemindedness in their concept of mental illness.

The Jewish group most often mentions the factors of "family or marital or sexual tensions" as causative agents in mental illness. They also exclude cerebral palsy and paresis from their concept of mental illness more frequently than do either Catholic or Protestant physicians.

Rural-urban differences. There are relatively few significant distinctions between doctors living in rural counties and those living in urban areas. This classification is highly dependent upon the type of practice; only 21% of the rural but 56% of the urban physicians are medical specialists.

Doctors in urban areas are more likely to report that there are local mental hygiene clinics available in their communities. Furthermore, they more frequently report that they do "quite a bit" of reading about psychiatry than do rural doctors. More of the urban sample say that they have visited one or more mental hospitals.

On the other hand, more of the rural doctors in this sample have been involved in commitment procedures, although they are less likely to make use of a psychiatrist than are the urban physicians. Finally, we may note that it is more usual for the rural practitioner to report he encounters "a good deal" of psychosomatic disease than for the urban doctor to do so.

SUMMARY

The general level of information among physicians in New Jersey is rather low on such questions as identifying the department responsible for running the state mental hospitals, the number of state mental hospital patients and the nature of the programs of several major institutions; the majority of doctors cannot offer correct information.

Although the majority report that they know of local general hospital facilities and clinic resources for the referral of patients in need of psychiatric care, the present study provides little confirmation of the existence and extent of concrete knowledge. Of those who say they know of local mental hygiene clinics, one-half cannot offer any information on the number of days per week that service is available. One-third of this group feels, however, that the local service is not adequate for the need.

Actually, the majority of the doctors recognize a shortage of psychiatric services in their community; nearly one-half emphasize that the problem is partially the need for low-cost treatment. Furthermore, most doctors feel that the state hospitals are not able to handle the job. It should be noted that a small but sizable group (over one-fifth of the sample) say they would not like to see more psychiatric facilities or clinics made available in their community.

Not one doctor in five says he does "quite a bit" of reading in psychiatry. There are other findings, however, which suggest that there may be an extensive latent interest in the specialty, *e.g.*, over two-thirds say they would like to have an informative pamphlet on the subject; 41% say they would definitely attend a seminar in psychiatry if

one were offered in their community and another 14% say they might. Also, two-fifths would like to see more psychiatrists on county medical society programs. We must note, however, that an almost equally large number say they would not. These findings suggest that there may be a sharp division of opinion about psychiatry within the medical group. The study indicates that at least a minority may be opposed to, or at best indifferent to, an expansion of the field.

Estimates are high of actual or potential neuropsychiatric problems in the part of the population encountered by doctors in their practice. The vast majority of doctors say they have often or occasionally felt it necessary to refer patients for psychiatric help. Nearly two out of five doctors say that 10% or more of their patients could benefit from the services of a psychiatrist. Furthermore, the majority of doctors report that 30% or more of their patients are suffering from a neurosis, and nearly half say that they meet up with "a good deal" of psychosomatic complaints. That doctors report a higher percentage of patients suffering from a "neurosis" than of patients who could benefit from psychiatric care indicates that a distinction is being made between disorders severe enough to require specialized treatment and those which are not. It would seem important to know more about the criteria utilized by doctors for noting emotional disturbances and gauging their severity.

The vast majority (88%) of doctors feel confident of their ability to make the differential diagnosis between a neurosis and a psychosis. Again, it would seem highly important to learn something of the process by which such a decision is made. Two-thirds of the doctors say they feel able to treat a neurosis; in fact, only 12% of the total said flatly that they did not feel qualified. It would be significant to have data which could tell us what methods the doctors use (or would use) in particular cases. In this study, we asked only what the doctors thought were, in general, the best methods of treatment for mental illness. One-third endorsed electroshock therapy; one-fourth mentioned psychoanalytic techniques. If a further study of doctors is to be made, it might be valuable to obtain more specific measurements on such questions as these: What percentage of their patients do the doctors actually treat for psychiatric problems? How do they decide whether such treatment is indicated? How do they decide upon the method or methods of treatment? What methods are used most frequently (*e.g.,* psychotherapy, reassurance and support, or drugs)? Diagnosis and treatment are closely related to notions about etiology. In the present investigation, when doctors were asked the most common causes of mental disorder, they referred more often to the tensions and anxieties which arise in the course of living (such as concern over health, or family problems). Three out of ten mentioned the factor of inherited predisposition; a nearly equal proportion mentioned various physical factors. Only 18% made any reference to early familial experience. Unfortunately, some of these coding categories lack precision. It seems evident, however, that the majority of doctors do not stress developmental factors in their etiological theories; they are "ahistorical" in their approach. Further research might seek to determine more exact information about etiological theories and their applications to specific cases, in terms of diagnosis, decision for the necessity of treatment, the mode of treatment (if the doctor essays it) and/or the nature of the referral.

Seventy-eight percent of the doctors have been involved in commitment procedures;

nearly one-third of these "only occasionally" or never use a psychiatrist as the other committing physician. The present study indicates a fairly widespread feeling of competence among doctors about coping with problems of mental illness. In juxtaposition, the finding that so few do any reading in the current psychiatric literature is somewhat disquieting. The present study does not provide a definitive assessment of competence; perhaps a future one shall.

The doctor may be regarded as a "gatekeeper" along the route to psychiatric treatment. Since he may be one of the first professionals to see potential mental patients, his judgment can often determine how many, how soon and where patients are to be referred.

LEO SHATIN, PH.D.

Some psychological aspects of long-term hospitalization

The rehabilitative role of recreational and special activities

The roster of special service in the treatment of the long-term patient includes recreational social activities, sports, various entertainments inside and outside the hospital, outings, music, the amateur radio station, and volunteer ward activities. From the very inception of our psychological program at this hospital we have worked hand in hand with the special service personnel. It has therefore been possible to gain an intimate understanding of the points of contact between that service and our psychiatric patients.

These remarks are addressed predominantly to the activities of the special service personnel insofar as they affect the welfare of the chronic psychiatric patient. However, it will not be too far afield to make certain observations which hold for the chronic patient whether he be medical or psychiatric.

The Veterans Administration Hospital at Albany, N. Y., is a 1,005–bed general medical hospital with some 300 beds allocated to psychiatric patients. Its mission has included a pilot program of care and continued treatment for the long-term mental patient. This pilot program embraced a rather new concept, namely, the treatment of aged chronic mental patients in a general medical and surgical setting, geographically located within an urban center and having only limited grounds.

This new and even radical concept sometimes necessitated drastic departure from the usual administrative patterns of a general hospital organization. Security measures were minimized. Psychiatric patients were encouraged to make the fullest possible use of all those recreational areas and activities which were available within the

Dr. Shatin, who is chief clinical psychologist at the Veterans Administration Hospital in Albany, N. Y., and associate professor of psychology at the Albany Medical College, delivered this paper at a conference on special services, held at the hospital on January 16–17, 1956.

building or its grounds. The many requisite changes in administrative practice, together with the rapid introduction of several score long-term mental patients within the brief span of but a few months, made necessary a decided change in the orientation of our hospital personnel. Apprehension arose in various quarters and had to be allayed. Attitudes had to be re-oriented and new treatment methods had to be learned. Naturally, employees as well as non-psychotic medical and surgical patients made frequent contact with the psychiatric patients. This created stressful situations at times.

We therefore undertook a program to demonstrate to the hospital community the potentialities for improvement of these older chronic mental patients with functional psychoses (2, 8). The prognosis for these patients is most usually viewed with extreme pessimism. In all frankness, the major purpose of this project was to heighten the therapeutic atmosphere within our wards and indeed within the boundaries of the hospital as a whole. The project was an aid to our own learning. It also constituted a focal point from which were disseminated those attitudes which would be most beneficial for the long-term psychiatric patient. Finally, the project was so developed that it provided an opportunity for the admixture of our demonstration long-term patients with younger and relatively acute patients, on the same ward and in the same living areas. This worked to the ultimate benefit of both.

Briefly, ten experimental and ten control patients, all with exceptionally poor prognoses, were matched individually for age, chronicity and behavioral ward adjustment. Their mean age was 56.2 years for the demonstration group and 58.6 for the control. Mean chronicity (years since first hospitalization) was 26.7 years for the demonstration group and 26.9 years for the control. Ward adjustment for the two groups was closely comparable. This was quantified by a behavioral rating scale developed for the specific purpose.

The control patients proceeded with their usual ward treatment programs throughout the duration of this project. These treatment programs were fully as comprehensive and adequate as those of any good psychiatric institution. But all demonstration subjects were combined into a social unit and removed to a separate open ward where they lived together with younger, less chronic patients. A variety of treatment methods was utilized, including group psychotherapy, corrective and physical therapy, hydrotherapy, music therapy, occupational therapy, recreational therapy and electroshock therapy.

All the rehabilitation and ward personnel concerned with the demonstration patients or their therapies met together weekly to discuss the progress of the patients. They described and debated the methods of handling special problems which arose throughout the course of the project. Every patient was evaluated with quantitative rating scales at the beginning of the experiment and at stated intervals thereafter over its total course of six months. Three main tools for evaluation were employed: (a) behavioral rating scale (5), (b) multidimensional scale for rating psychiatric patients(4) and (c) weekly rating scale (2). I will not go into the details nor the rationale for these scales. Insofar as the quantitative results were concerned, they all demonstrated manifestly increased superiority of the demonstration patients over the control patients. This superiority improved with time. It was most graphically portrayed by the objective statistical results and tabulations (2, 8). The control group remained unimproved and even

showed some minor deterioration according to the multidimensional rating scale.

Three case historical sketches are presented below.[1] They exemplify the type of patient treated and they concretize the qualitative results.

Patient D1, hebephrenic schizophrenic, age 58, first admission 1920, continuously hospitalized. Extreme hoarder, stuffed cigarette buts, dirty linen, etc., into his clothing. Appeared humpbacked because of a large wad of newspapers he carried about. When addressed, gave a vigorous nod of the head and said "Yeah," but did not otherwise speak. Paced about a good deal. Always wore a dirty cap.

Patient improved following EST. He did not insist on wearing his cap and his hoarding behavior abated. He seemed eager to gain attention and recognition and would hold out his hand to personnel to shake. Fifteen weeks after the experiment, the patient maintained some improvement but continud to hoard worthless items. When confronted with his behavior, he feinted at his accuser although he is not assaultive. He was recommended for further EST.

Patient received two more EST during the 15th experimental week, three during the 16th, and one during the 17th week. He became subdued but more cooperative and friendly with ward personnel. His hoarding behavior ceased and he no longer insisted on wearing his cap. He was given a limited privilege card which entitled him to go off the ward in the company of another demonstration patient who had full privileges. Thereafter he visited the canteen daily and participated in off-station trips.

D1 assumed the role of ward helper, cleaning sinks and making beds. He took no property from other patients' rooms, showed generosity with his cigarettes and literally amazed the ward personnel with his cooperative behavior. A brief period of regression followed and he began to wear bedclothing for decorative purposes. This behavior soon ceased. Patient formed a close relationship with the occupational therapist and desired to please her. He was unresponsive during a visit from his family, the first received in a very long while. He was, however, reaching out to ward personnel for attention and seemed desirous of forming closer relationship with the people who were helping him. At the close of the demonstration project, D1 continued to share a room on the ward with the patient who had full privileges and in whose company he participated in industrial therapy.

Patient D2, hebephrenic schizophrenic, age 55, first admission 1920, continuously hospitalized, was silly, acted the part of the "clown." Constantly gestured to gain attention. Exhibited his knees, breasts and teeth in grotesque fashion. Legs were ulcerated due to constant picking and irritation. Spoke in a loud, garbled, incomprehensible fashion. Smoked cigarette with burning end in his mouth, then used the wet end to write on the wall.

At the very start of the experiment, an increase in the patient's abnormal behavior was noted. He broke a window, loosened light fixtures and distributed wrapped feces about the ward. The patient received only two EST because of medical contra-indications, at which time he was transferred to an infirmary ward. Here he became extremely passive and infantile. Following transfer back to the demonstration ward his behavior again became oriented toward

[1] Reprinted by permission of the *Journal of Nervous and Mental Disease* (2, 8).

obtaining attention. Fifteen weeks after the experiment this patient no longer destroyed property. Occasionally he was pleasant in conversation. His bizarre mannerisms were less evident.

Patient received one EST during the 15th experimental week and one weekly from the 17th through the 21st weeks. Immediately following this treatment he became less active and seemed to feign the illness which had occurred after his first series of EST. Periods of hyperactivity ensued, when the patient sought to gain attention. On two occasions he defecated on the floor of the dining room and once he overturned an elderly patient sitting in a wheelchair. When placed in ten minutes' seclusion for this latter act, D2 realized that he was a "naughty boy." His appetite gradually improved, as did his speech, which was now more clearly enunciated. Toward the end of the demonstration period he reverted to gesturing with his feet and hands. During group psychotherapy there were five occasions when the patient seemed to have some insight into his behavior. At the termination of the project he was not considered capable of adjusting adequately on this open ward with fully privileged patients. Hence he was transferred to another open ward with long-term patients at a lower level of adjustment.

Patient D9, paranoid schizophrenic, age 58, first admission 1924, four subsequent admissions, continuously hospitalized since 1948. He was extremely paranoid, and would walk away from personnel who approached him but followed personnel when they left. Constantly asked to be discharged to New York City. Used to shout and to kick at the door when angry. Said there was a machine outside which influenced his thoughts. Said that all records which are dictated by doctors are about him. Never sat down, was always pacing.

Patient improved while receiving EST, related himself very well to personnel, and was pleasant and cooperative for a brief time. He regressed somewhat temporarily and began demanding to go to New York City. After that he again improved. Fifteen weeks after the experiment, patient showed dramatic improvement. He had a privilege card, went out on pass unaccompanied, and was an assistant in the recreation sports section, where he did an excellent job. He made friends in the hospital. He had some physical complaints but considered himself ready for discharge. He had dissociated himself from the demonstration group and preferred to seek friends among the hospital personnel and among those patients who are not psychotic.

Patient D9 received no additional EST. Because of his improvement and because he was doing so well as assistant to the recreation sports department, this patient was discontinued from active demonstration group therapy. He effected an adjustment at a level far superior to that of all other patients in the group. He now felt nothing in common with them. He was reassigned to a psychotherapeutic group composed of younger, more acute patients. Patient reacted rather adversely to this new group therapy and was soon discontinued. He was visited later by his sister and had a pleasant time with her despite her refusal to arrange a leave or accept any responsibility for him. Personnel were surprised to note no regression in the patient's behavior after this visit. He continued to have privileges, lived in a 2-bed room with one of the younger patients and worked on his industrial therapy assignment. He became an important member of the recreation sports department and was voted "patient of the week" by the hospital newspaper. He maintained his excellent ad-

justment and made frequent off-station trips. He wore his own clothes rather than the hospital issue. Patient complained about numerous physical symptoms, none of which he had mentioned when he was mentally ill. He was generous in his gifts to the staff, purchasing cigarettes and tobacco for them, and was eager to form friendships with staff members. Patient became concerned about money and about the fact that he would have no job when he left the hospital. At his own request he was given a 3-day pass to visit New York. He traveled by himself, stayed in a hotel, and visited his family and old business acquaintances. He returned to the hospital quite buoyant and enthusiastic. Patient then requested frequent Saturday or Sunday passes and utilized them well. At the termination of the demonstration project he was continued on the same privileged open ward.

I wish that we could have good quantified materials such as were so beautifully available in the statistical tables (8) to portray by contrast certain of the intangible benefits which were derived from this project. These intangible non-quantifiable benefits were fully as important as the measurable results, if not more important.

Considerable interest was elicited among the professional and administrative staff. It was a difficult, complex type of project that could be accomplished only through the wholehearted cooperation of many services and divisions. It drew them all into its functioning organic unity. The program constituted a definite learning and growth experience for all staff members involved. Staff person learned from staff person. We learned what the other fellow had to offer and we also learned the practical limitations of his professional role. We accepted that which he could give; but we also accepted his limits. We learned how to use the knowledge and potential contribution of all the vocational roles that came together in this project. Hence the benefits derived were permanent. They were disseminated to the benefit of many patients not then within the project itself.

Final individual interviews were conducted with the staff participants to ascertain their personal reaction to this demonstration program. It was made patent to us that staff morale remained high and that enthusiasm for the learning of treatment methods and the solution of new problems was undiminished at the end of the last month of the experiment. This program remained a high point in the hospital experience of all participants. In our judgment this project successfully demonstrated to the hospital community that older, chronic mental patients can be improved by the determined application of a modern and comprehensive treatment program. We felt that it contributed enormously to hospital-wide acceptance of our psychiatric treatment program for long-term patients.

At the conclusion of this demonstration project a similar program (now non-experimental) was instituted on one ward with 47 chronic psychiatric patients. The general ward atmosphere and approach is similar to that of the original demonstration project. The latter constituted the basis for this ongoing program, which now functions with a more limited staff but continues to act as a central focus of learning and treatment.

The special service section made a decided contribution to the demonstration program I have just described. It was part and parcel of our complete rehabilitation effort. Recreation therapist and music therapist, both representatives of the special service section, participated in our weekly staff conferences. The recreational

facilities, the off-station visits, the bus trips and the many other recreational activities contributed vitally to our whole effort. The rhythm band in which our demonstration patients participated actively, and the recorded folk music which we utilized—both were made available through the efforts of the special service section and its volunteers. The ways in which we then learned to use the special services have been carried through in several directions which I will touch upon.

I remember well the rhythm group session where the demonstration patients began to dance in a kind of conga line or snake dance. This would have been beyond our wildest dreams at the outset of the project. The rhythm group sessions, held twice weekly, were attended by a music therapist and a clinical psychologist. Live music—the man with the piano—contributed to the vitality of the music rhythm activity. Some few times it was necessary to use "canned music." This, of course, was better than no music at all, but it lacked the drive and impetus given by the piano with the live musician.

It was through this demonstration experience that I, and all of us who participated, became keenly aware of rehabilitation functions which could be implemented by the special services.

The activities provided by our special service personnel were an integral part of our rehabilitation effort, and were accepted as such by all participants. Rehabilitation does not necessarily mean recovery to the point of discharge or to the point of social and economic self-sufficiency. It includes a preventive concept, the retardation of the process of deterioration. Rehabilitation can mean the deceleration of that usual deterioration which occurs when hospitalization goes on and on, through the months and through the years. The deterioration which comes from long hospitalization is not necessarily a consequence of the disease *per se.*

The chronic patient, medical or psychiatric, devaluates himself from the very beginning of his hospitalization and thereafter (9). He perceives himself as disabled and inferior. His self-concept and his body image necessarily change in a negative way. He goes through a period which might be termed "mourning" when he tries to reorient himself to his new and devaluated self-concept. He shows a narcissistic withdrawal of interest from the outside world and turns his interest in upon himself. This is furthered when the patient is treated as an *object,* as if he were unfeeling and emotionally uninvolved, as an example of an illness or disease rather than as a person who is suffering. The special service section counters this by providing contact with the world outside. Through its entertainment, its visitors and its trips, it maintains the patient's contact with the world of health, with the usual world channel of communication back into the ordinary world outside. Especially for the chronic patient, the patient who is and will be hospitalized here for years, must such a channel be maintained and strengthened. Off-station trips, television, radio, newspaper, books, performers, parties, games—these maintain the patient's contact with the normal and active world of health. Here is an emphatic need for every facet of special services.

These special services are not simply diversionary, something to "keep the patient happy." They are used with a definite aim and with a definite purpose: in other words, as a treatment modality. This is not to say that many nonspecific facilities are not provided by the special services. Indeed they are, and are very useful as such. But over and above this the special

service section can, and here does, serve as an integral part of our rehabilitation armamentarium.

I have given much praise to the special service section. This does not mean the relationship among our sections has been continually smooth and acceptable. However, the essence of relationship is this: we know our own limitations and we know the other's limitations. We know how to utilize each other's professional services to meet the needs of the patient.

You may notice that I have avoided the words *team* and *teamwork*. This is not merely a personal predilection. The self-conscious use of the word *team* implies an underlying feeling that perhaps there are members participating who are not really and originally a part of the team. It smacks of the psychological mechanism of compensation. And this is not the case. In a joint, coordinated effort, every participating member contributes mightily to that effort. The nurse, the nursing assistant, the social worker, the vocational counselor, the music specialist, the librarian, the recreation therapist—none has to prove himself. He has already done so over and over again.

In cooperative hospital undertakings such as our demonstration program, certain principles of human relations assume paramount importance. First of all, the technical jargon of any rehabilitation discipline, whether it be psychology or psychiatry or recreation, should be avoided. Basic English serves very well as the medium of communication. Secondly, one must be cognizant that the participants constitute a socially interacting group with all the dynamics, needs and motivations which exist in such groups. Thirdly, the group should be structured not as a hierarchical relationship but rather as one in which all have an equal and accepted voice. If anything is to be accomplished over the long haul, through the years rather than toward a single immediate short-term goal, congenial relationships must be maintained. Some of the problems which are likely to arise (3) are problems of status, of bypassing the chain of command and the channels of communication, of clashes between the "idea man" and the "practical man." A staff member who enters the project at some date after its inception may be in danger of feeling rejected. All this must be anticipated. It can be avoided by joint planning, by full and frequent group discussion, and by making known the realistic divisions of the duties of all.

In preparing this paper I recalled some points of contact and communication with special services. This was indeed an eye-opener. Let me show you why.

Two years ago we became interested in the effect of music on the speed of awakening following electroshock treatment. Our special service section, hearing of our interest, created a liaison with a volunteer organization [1] which then provided technical assistance and worked with us on a continuing basis throughout the project. Hence, through the efforts of the special service section, the particular types of music we needed and the particular record-player we desired were made available. Our efforts ultimately culminated in a controlled study of the relationship between music and post-electroshock awakening (6). This has given some promising leads which we hope are worthy of further exploration.

In our group psychotherapeutic program with the long-term psychiatric patients we

[1] Hospitalized Veterans Music Service of the Musicians Emergency Fund, Inc., New York, to whom grateful acknowledgement is made for their generous technical and advisory assistance in our many music projects with veteran patients.

began to apply rhythm instruments. At least two of our groups now have a schedule which includes verbal psychotherapy on one day of the week and rhythm participation on another day of the week. The rhythm participation helps to draw the men together and assists their entry into the formal group organization. A summary of our knowledge gained through this medium, and a description of its functional application, was recently reported (7).

About a year and a half ago we organized a group treatment program for aphasic patients. This was not a speech reeducational program. Rather was it concerned with the emotional and social problems of our aphasic patients, most of them elderly and long-term. We desired to create an informal, pleasant, socially enjoyable group atmosphere. The special service section provided us with two mature female volunteers, very appropriate to the motherly role. These volunteers offered refreshments at the weekly meetings and participated actively in the social proceedings. Music facilities were also utilized, both for group singing and group rhythm band. Much was accomplished through this group, which is still active and thriving (1).

The use of music during electroshock treatment is widespread throughout the United States. The prevailing general impression is that music tends to alleviate the fear of patients while awaiting treatment. At Albany we have been fortunate in securing fine provision for such music. Last year we also undertook a program to investigate quantitatively whether music actually alleviates the patients' fear of treatment. Materials such as music records and special tape machines were made available to us under the auspices of the special service section and its volunteers.

We utilized certain types of abstract movies, where form and color were combined together with music, especially to evoke planned emotional reactions among our patients. Once again we called upon the special service section and its volunteers to provide us with a film and to make available to us the auditorium set-up as well as the movie operator. A weekly therapeutic film program for psychiatric patients is conducted under the auspices of a psychologist and a psychiatrist. The leaders require the service of the recreation department for the formal execution of the plan: locale, projectors, operator, etc. This program stimulates a definite beneficial reaction within the patients. It induces them to explore their problems within a psychotherapeutic group setting, and makes it difficult for their avoidant-repressive mechanisms to dodge the issue—as too often had been the case.

Over and over again I have found in my psychotherapeutic groups, conducted with neurotic patients, that the patients discuss the social contacts they make in the recreation hall and in the radio room of the special service section. These areas provide a segment of life where the usual daily problems of living, not so easily available within hospital walls, may arise. Such experiences reveal in a microcosm that type of social difficulty which has occurred throughout the patient's whole life. It provides the psychotherapeutic group leader with important social material—within the group setting. There he may discuss the patient's perception of the social situation and the adequacy of his reaction to that situation. I doubt very much that our special service department knows how often it has been damned by individual patients within the group therapy setting! This is of course to the credit, not the discredit, of the special service section. Since our ambulatory privileged patients so often do have contact with special services, the latter

provides a frequent focus for their frustration and hostility. This comes to a fruitful culmination in our psychotherapeutic groups. It provides the concrete material of life, the here and the now, which may be fruitfully discussed and resolved in psychotherapy.

While on duty at a hospital in New England, I had occasion to examine a patient, an elderly man, who was rejected by his wife and who was being considered for transfer either to Albany or to a domiciliary home. On my arrival in Albany I met this same patient once again. He was participating daily in the radio activities of the special service section. The change in his attitude toward life, his now-strong joy of life, was profound. It was in decided contrast to his previous state of morale. Where before he had been discouraged, had felt rejected and had nothing to look forward to, now he had a definite social orbit and realm of competence within the sphere of special services.

Many times, and for many reasons, we have needed to make tape recordings of psychological activities. I assure you, it has been most gratifying to have the cooperation of an expert from the special services department. It has enabled us to hold more effective conferences and to make more adequate evaluation of the results of such conferences.

A social dance program for mental patients is conducted with the assistance of Red Cross volunteers. The departments of psychiatry, psychology and special services have had several joint meetings to discuss the organization of a project designed to evaluate carefully and without bias the actual effect of the dance program on the patients and on their desire to enter into social relationships. We intend to evaluate quantitatively the attitudes of ward personnel and participating volunteers, as well as the attitudes of the patients themselves.

In our newer service program, the offshoot of the demonstration program, we have experimented with the use of the library as a treatment method for long-term psychiatric patients. The chief librarian has introduced our long-term mental patients into certain bibliotherapeutic activities involving group discussion on matters of topical interest. We have also begun to study the reading interests of psychiatric patients and to compare them with the reading interests of patients in the medical and surgical services.

The recreation section has devised some important openings for industrial therapy. Several of our long-term patients have functioned most adequately within the atmosphere and the setting provided by the recreation department. These patients have been of decided assistance to the recreation staff at the same time as the activity itself has been a rewarding and rehabilitating experience for the patients. In these several instances of which I speak the recreation section has provided a stepping-stone into the member-employee position or into the night hospital type of arrangement.

You may be familiar with the hospital newspaper which is published under the auspices of the special service section. This has been an important focus for certain of our patients. It has provided them with an incentive to write and to explore the various hospital departments for topics about which to write. Some of our patients have assisted in the administrative aspects of the paper rather than as writers. In all cases they have shown a strong sense of growing responsibility and of belongingness to the newspaper group. The newspaper has also provided our most disabled patients with an activity which they can accomplish on the ward under the supervision of occupational therapy, namely, the

assembly and stapling of the newspaper sheets. This is a weekly activity which occurs on Friday morning and is a distinct part of the Friday morning routine. One of the long-term patients then distributes the paper to us in the psychiatric service. This is an important rite to him; he distributes the paper to all points, and accurately so. From this he has gained a proud sense of accomplishment, and with it, a sense of responsibility.

Just recently an interesting event occurred. The recreation department informed me that we would have a newspaper article published about some of the activities of the psychiatric service. I was asked whether a reporter might speak to the patients in one of our psychotherapeutic groups. That same day I took up the matter with a group of young and alert psychoneurotic patients. In group discussion they rejected the idea of having an observer. They felt this would immediately defeat the purpose of group psychotherapy. After some further discussion they came up with an excellent idea. They asked to have the Thursday session of the group therapy cancelled. Instead, the news reporter might come in and conduct a small forum with the group. The group would be glad to answer any questions about group treatment or other activities, provided the questions were not personal. The group was eager to make known to the general public and to employers, through the medium of the newspaper, their positive feelings about the hospital and about the general atmosphere in our service. They desired to do their bit to fight prejudice against persons with mental disorders. This forum was held. It really did constitute a gratifying experience to the patients. It gratified me as their group therapist, in that they showed sufficient initiative to resolve the problem and to take action toward a well-conceived goal.

Psychological rehabilitation is a matter of attitude; it is a state of mind. This attitude is not the prerogative of any one guild. The rehabilitative attitude—like gold—is where you find it. The medium of communication to the patient does, of course, vary with the role of the staff member. But each can in his own very special way give of himself and of his strength. In this lies the secret of its success.

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MORTIMER M. MEYER

Who returns to the clinic for more therapy?

Frequently when psychotherapists are exchanging comments about individual patients or therapy in general, the remark is made that all the old cases are coming back to the clinic, that all the closed cases have had to be re-opened. The frequency of these comments stirred our curiosity as to the facts. Is this impression in the same category of selective perception as the old saw: "Every time I carry an umbrella it doesn't rain?" Or is there some valid basis for the somewhat somber conclusion that only a small number of the patients treated in our clinic are helped to live a reasonably comfortable, socially adjusted and independent life without further help from the clinic?

Our Veterans Administration mental hygiene clinic, a therapy clinic, has been functioning now for more than ten years and has about 5,500 closed cases. It was time to take stock. We took as a sample for study the case files in every third drawer of cases closed since the clinic started. These closed cases include the files of patients who were in treatment until completion of therapy, those who left treatment before completion, and those who were not accepted for treatment. Among these cases further selection occurred. Since our first question was: "What proportion of *treated* cases come back to the clinic?", we had to define "treated" arbitrarily. A previous research study at the clinic indicated that patients who remained in treatment for five sessions were more likely to continue until com-

Before her recent death Dr. Tolman was on the staff of the Veterans Administration's mental hygiene clinic in Los Angeles. Dr. Meyer is chief psychologist there.

pletion of treatment. We therefore chose five or more therapy sessions (including the intake interview) as the definition of "treatment." Although this definition was not rigorous, it had the advantage of being based on some research with the same population.

Even further selection occurred. We limited the cases to those for whom a "closing summary" appeared in the file. The closing summary was introduced in the records of the clinic in 1949 and contained the following items: Patient's name, date patient entered therapy and date case was closed, number of therapy sessions in the clinic, marital status of patient, occupational status, diagnosis, reason for closing the case and therapeutic status when case was closed. In addition, the following items were obtained from the "face sheet": sex, race and date of birth.

All of these data were used. All are relatively superficial and there is no item which points to any of the deeper dynamics of the patient. But it was felt that to look at even these simple facts in relation to the tendency to return for therapy might provide some useful information. Could we find any differences in these items between those who come back to the clinic for more therapy and the total sample? Distributions of the data computed separately for the total sample and for those who did not return were practically identical; we therefore chose to compare those who returned with "the average patient" of the total group rather than with those who did not return.

Our interest was not only in the patient who comes back. We were interested also in the over-all picture. How do all patients stand on these variables? How about the ones who improve markedly and those who make only a slight improvement? How about those who stay the same?

TABLE I

Date of birth of all patients in sample

DATE	NUMBER	PERCENT
Before 1900	7	2
1900–04	9	2
1905–09	25	7
1910–14	41	12
1915–19	60	17
1920–24	130	36
1925–29	67	19
1930–34	13	4
No information	2	1
	354	100
Median	1921.3	

TABLE II

Number of therapeutic sessions of all patients in sample

NUMBER OF SESSIONS	NUMBER	PERCENT
5– 14	133	37
15– 24	66	19
25– 49	77	22
50– 74	38	11
75– 99	17	5
100–149	10	3
150–199	5	1
200–and over	8	2
	354	100
Mean 38 Sessions		
Median 22 "		

THE AVERAGE PATIENT

Our sample consisted of 354 cases. Ninety-four percent of these were white, 89% were male. On the other recorded variables which have been mentioned, these patients were distributed as shown in Tables I to VII.

TABLE III

Closing therapeutic status of all patients in sample

STATUS	NUMBER	PERCENT
Much improved	88	25
Slightly improved	138	39
Maximum benefit	15	4
Unimproved	107	30
No information	6	2
	354	100

TABLE IV

Reason for closing cases of all patients in sample

REASON	NUMBER	PERCENT
Treatment completed	78	22
Hospitalization	11	3
Patient discontinued—informed therapist	125	35
Patient discontinued—did not inform therapist	77	22
Other [1]	63	18
	354	100

[1] The category of "other" includes such circumstances as the patients' leaving town, taking full-time jobs, departure of therapist from the clinic, etc.

TABLE V

Marital status of all patients in sample

	AT INTAKE		AT CLOSURE	
STATUS	*Number*	*Percent*	*Number*	*Percent*
Single	100	28	95	26
Married	204	58	204	58
Divorced	29	8	33	9
Separated	19	5	20	6
Widowed	2	1	2	1
	354	100	354	100

TABLE VI

Occupational or educational status of all patients in sample

	AT INTAKE		AT CLOSURE	
STATUS	*Number*	*Percent*	*Number*	*Percent*
Employed	182	51	232	65
School	53	15	45	13
Unemployed	119	34	77	22
	354	100	354	100

TABLE VII

Diagnosis of all patients in sample

DIAGNOSIS	NUMBER	PERCENT
Psychoneurotic reaction	233	66
Psychotic reaction	47	13
Character disorder	52	15
Miscellaneous	22	6
	354	100

To summarize, our "average" (modal) patient is a white male born between 1920 and 1924. He came to the clinic for an average of 38 therapeutic sessions and he left "slightly improved," discontinuing therapy after some discussion with the therapist. He was married and employed, but more likely to be employed at the end of therapy than at the beginning. The most common diagnosis was one of the psychoneurotic categories, especially anxiety neuroses.

PATIENTS WHO RETURNED FOR FURTHER TREATMENT

Of our total sample only 12% returned to the clinic. Of this 12%, 9% returned once, 2% twice, 1% three times. Eighty-eight percent, therefore, never returned. The small group who returned to the clinic for further treatment were, like the total sample, predominantly white (95%) and male (93%).

Among the patients who had come to the clinic but who had not been "treated," that is, who had come for fewer than five interviews, the proportion of patients who returned was even lower. A check on returns among a sample of 431 of these patients showed that only 25, or 5.8%, returned later. We could reasonably assume that the lack of motivation for therapy which prevented their continuing in the first place also prevented their return.

TABLE VIII

Date of birth of patients who return

DATE	NUMBER	PERCENT
Before 1900	1	2
1900–04	0	0
1905–09	4	9
1910–14	9	21
1915–19	7	16
1920–24	19	45
1925–29	3	7
	43	100

Median 1920

TABLE IX

Number of therapeutic sessions of patients who return

NUMBER OF SESSIONS	NUMBER	PERCENT
5– 14	13	30
15– 24	7	16
25– 49	17	40
50– 74	4	9
75– 99	2	5
100–149	0	0
150–199	0	0
200–and over	0	0
	43	100

Mean 31 Sessions
Median 27 "

Tables VIII through XIV give for the patients who return to the clinic data similar to those shown in Tables I through VII for the total sample.

The data in Table X arouse a question. What therapeutic gain is accomplished by these "repeat" visits to the clinic? It is apparent that the final judgment of therapeutic status shows no improvement over the status at the first closing, the proportions in the "improved" and "unimproved" categories being approximately the same in the two distributions. The average number of sessions after return of these patients was 25, so the result cannot be attributed

TABLE X

Closing therapeutic status of patients who return

STATUS	FIRST		FINAL	
	Number	*Percent*	*Number*	*Percent*
Much improved	12	28	10	23
Slightly improved	17	39	16	37
Maximum benefit	3	7	3	7
Unimproved	11	26	14	33
	43	100	43	100

to the fact that no further therapeutic work was done with them. The small size of our sample must make inferences tentative, but we can reflect soberly that we should be cautious in expecting great additional therapeutic benefits from these further treatment sessions. It may be that these repeat visits should be viewed as an opportunity to consolidate the gains made in the previous therapy.

To summarize (although these inferences must be regarded as tentative because the number is so small), our patient who returns to the clinic does not differ markedly from our "average" patient. He is slightly older but this difference is not statistically significant.[3] He has come to the clinic for a number of therapeutic sessions that is slightly lower than that of the total group. This difference is also not statistically significant. He too has left "slightly improved" and was discontinued after some discussion with the therapist. He was less likely than the average patient to be married and more likely to be single at the time his case was closed. He was less likely

TABLE XI

Reason for closing cases (first treatment period) of patients who return

REASON	NUMBER	PERCENT
Treatment completed	10	23
Hospitalization	3	7
Patient discontinued—informed therapist	15	35
Patient discontinued—did not inform therapist	8	19
Other [2]	7	16
	43	100

[2] The category of "other" includes such circumstances as the patients' leaving town, taking full-time jobs, departure of therapist from the clinic, etc.

TABLE XII

Marital status of patients who return

STATUS	AT INTAKE		AT CLOSURE	
	Number	*Percent*	*Number*	*Percent*
Single	18	42	18	42
Married	20	46	19	44
Divorced	3	7	4	9
Separated	2	5	2	5
	43	100	43	100

[3] The formula used was that for standard error of difference between two percentages:

$$100\sqrt{\frac{P_1Q_1}{N_1}+\frac{P_2Q_2}{N_2}}$$

TABLE XIII

Occupational or educational status of patients who return

STATUS	AT INTAKE		AT CLOSURE	
	Number	*Percent*	*Number*	*Percent*
Employed	15	35	27	63
School	10	23	6	14
Unemployed	18	42	10	23
	43	100	43	100

to be employed than the average at the time of intake, but by the conclusion of treatment his employment status had improved and coincided with that of the average patient. The differences in both marital and employment status are significant at the .05 level. In diagnosis there were no differences between the patient who came back to the clinic for more treatment and the total sample.

THE IMPROVED AND THE UNIMPROVED

Our interest, as has been said, was not alone in the patients who came back for more therapy. We looked also for possible differences between the patients who improved and those who did not.

Figures 1 and 2 and Tables XV and XVI give for the three groups *much improved, slightly improved* and *unimproved* comparable data to those shown in preceding tables. Percentages only are presented. Data on date of birth are not included because on this variable the distribution coincided so closely with that of the total group of patients.

It is clear from Figure 1 that the unimproved group has a much greater proportion (67% as compared with 34% and 10%) who have come to the clinic for fewer than 15 sessions. Conversely, the much improved group has a far greater proportion who have continued treatment for 25 or more sessions (71% compared

TABLE XIV

Diagnosis of patients who return

DIAGNOSIS	NUMBER	PERCENT
Psychoneurotic reaction	24	56
Psychotic reaction	9	21
Character disorders	7	16
Miscellaneous	3	7
	43	100

FIGURE 1

Number of therapeutic sessions by therapeutic status

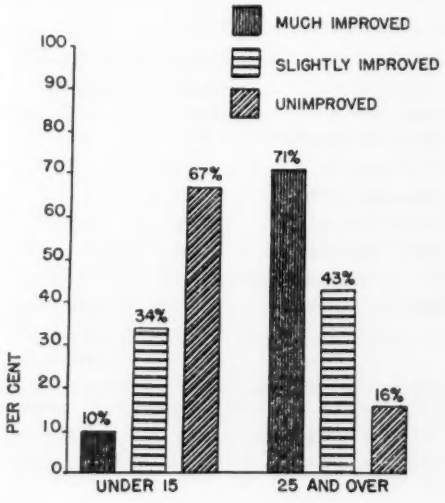
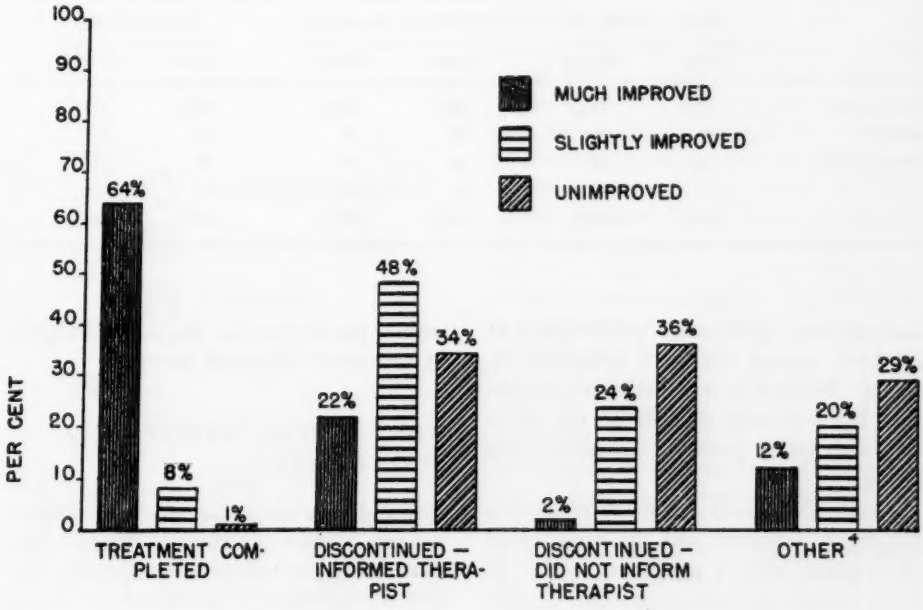


FIGURE 2

Reasons for closing the cases



[4] The category of "other" in this figure includes hospitalization, patients' leaving town, taking full-time jobs, departure of therapist from the clinic, etc.

with 43% and 16%). These differences are statistically significant at the .01 level.

In Figure 2 the most striking difference is the far greater proportion of much improved patients (64%) who "completed treatment," in comparison with the 1% of the unimproved where this was given as the reason for closing the case. At the other end of the scale is the very small proportion of much improved cases (2%) who discontinued therapy on their own without informing the therapist. Of the unimproved patients 36% discontinued in this manner. These differences were significant at the .01 level.

In regard to marital status at intake and closure, there were no significant differences among these three groups.

Table XV shows two important differences in occupational status between the much improved and unimproved cases, both at the time the cases were closed. At closure there were significantly more employed and fewer unemployed within the group of much improved, in comparison to the unimproved where there were more unemployed and fewer employed. Not only were these differences reliable at the .01 level, but the proportoin of patients who moved out of the unemployed

TABLE XV

Occupational status in improved and unimproved cases

	MUCH IMPROVED		SLIGHTLY IMPROVED		UNIMPROVED	
	Intake	*Closure*	*Intake*	*Closure*	*Intake*	*Closure*
Employed	56%	75%	52%	67%	47%	53%
School	20	14	12	14	15	10
Unemployed	24	11	36	19	38	37
	100%	100%	100%	100%	100%	100%

category was significantly greater (also at .01 level) among the much improved patients. Hence it is reasonable to conclude that the successful therapy of the much improved group probably determined this change.

Table XVI shows a difference between the much improved and the unimproved in diagnosis that is significant at the .02 level, namely, that the proportion of cases with a psychoneurotic diagnosis is higher in the much improved group.

TABLE XVI

Diagnosis in improved and unimproved cases

DIAGNOSIS	MUCH IMPROVED	SLIGHTLY IMPROVED	UNIMPROVED
Psychoneurotic reaction	74%	68%	58%
Psychotic reaction	8	11	20
Character disorders	14	14	16
Miscellaneous	4	7	6
	100%	100%	100%

WHAT KIND OF PATIENT STAYS LONGEST?

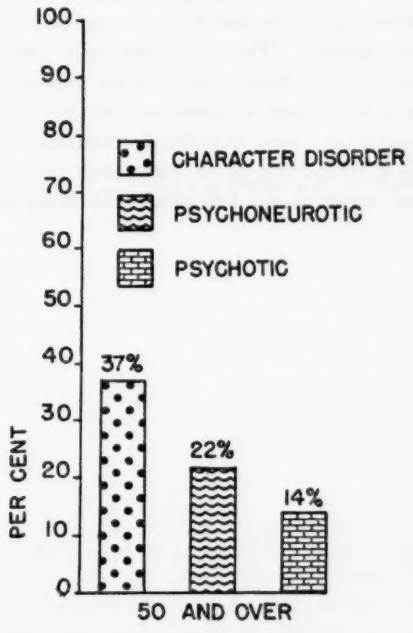
Although it is often assumed that psychotic patients remain in therapy longer than those with psychoneurotic diagnoses, our data show no significant difference between the proportions of these two groups who came to the clinic for 50 sessions or longer. Differences in this respect are apparent, however, between patients with a diagnosis of character disorder and the other groups. Figure 3 indicates that 37% of the patients with character disorder remain longer in therapy (50 sessions or more) as compared to 22% of psychoneurotic patients and 14% of psychotic patients. The former difference is significant at the .05 level and the latter at the .01 level.

DISCUSSION

It must be noted that the ratings of therapeutic status are very subjective. A condition which to one therapist may appear as "much improved" to another might make

FIGURE 3

Number of therapeutic sessions by diagnostic category



the impression of "slightly improved." In this study there is no way of correcting for these differences in subjective impression nor of arriving at any objective method of comparing or equating judgments.

The same situation holds true in regard to the reason for closing a case. The judgment of "treatment completed" cannot be differentiated objectively from "patient discontinued—informed therapist." If the "information" coincided with the therapist's judgment that probably therapy had produced such results as were possible and that no further treatment would be profitable, the same situation could be described in terms either of "treatment completed" or of "patient discontinued—informed therapist."

Two other factors might enter into the judgment of the therapeutic status. The finding that "much improvement" is associated with a longer period of treatment might well result from the fact that therapists have a bias in favor of those patients who continue long in treatment, with whom a more intensive relationship develops. Hence the fact that a larger proportion of "much improved" cases come for 50 sessions or more and a smaller proportion of the "unimproved" stay so long in therapy may again be influenced by the nature of the judgment.

In a similar way the matter of employment or unemployment may enter into judgments of therapeutic status. Is a patient employed because he is improved, or is he judged to be improved because he is now employed while formerly he was unemployed? This kind of question bedevils the inquirer who must deal with the kind of data which furnish the material for this study.

The question could be raised: Did these clinic patients go into treatment elsewhere? In this community there are three sources other than the Veterans Administration clinic to which they might turn: community clinics, private therapists and VA contract therapists. Community clinics in this area do not accept veterans whose disability is service-connected. Very few would be likely to pay for private therapy when treatment without fee is available. As to the VA contract therapists, an attempt was made to examine the records of such treatment but this proved not to be feasible. Therefore the extent of use of this resource could not be evaluated, although it is estimated to be small.

SUMMARY

A sample of 354 closed case records randomly selected from the files of a Veterans Administration mental hygiene clinic were examined. An attempt was made to discover what differences in certain variables existed between those patients who returned to the clinic for further treatment and the average patient; also between those patients who were judged to show improvement in the course of therapy and those who were unimproved. Those patients who returned were significantly less likely to be married than the average patient. They were also significantly less likely to be employed at intake, but by the conclusion of treatment their employment status had improved and coincided with that of the average patient. The improved and unimproved cases differed in that the improved were more likely to have come to the clinic longer, to have completed treatment, to have moved out of an unemployed status and to be in the psychoneurotic category.

ROBERT W. SPAULDING

Some current trends in fee charging in community clinics

Fee charging has become an increasingly accepted practice of voluntary health and welfare agencies. Considerable content of the literature has been focused on the cultural and psychological significance of fee charging. As this practice has become more widespread the use of a fee system has also gained some recognition as a method of augmenting the agency's income.

Policies and procedures in relation to fee charging vary from agency to agency and from community to community. This informal survey represents an attempt to learn some of the current trends and practices related to fee charging in Iowa's Community Mental Health Centers. The original purpose of this study was to share the collective information regarding fee policies with the individual centers. No attempt was made to evaluate these practices and policies.

Iowa has nine Community Mental Health Centers now in operation. These clinics are supported from a combination of county tax funds, Community Chest funds, fees, private donations and federal funds available under the National Mental Health Act. These federal funds are administered by the Iowa Mental Health Authority, which also supplies consultant services and limited supervision to all the Mental Health Centers. Eight of the nine centers have developed under the auspices and guidance of the Iowa Mental Health Authority and have been established since the passage of the National Mental Health Act.

Eight of the nine centers responded to requests for information relative to their

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practice of fee charging. The information was gained through personal interviews with the clinic administrators, completion of a questionnaire and study of the actual fee schedules of the centers.

Six of the eight reporting Mental Health Centers base their fees on gross income. The remaining two centers base their schedules on net income, defining it as "the remaining income after income tax and social security only have been deducted from the gross income." In all centers, the fee policy has been reviewed by the respective boards and officially accepted as clinic policy. Although the Iowa Mental Health Authority offers consultant services to individual centers on their fee policies, the individual centers and communities formulate these policies at the local level.

Some centers have a flat fee for diagnostic service which remains the same regardless of the type of diagnostic service given or the number of visits needed to complete the diagnostic evaluation. Typically in such centers the one diagnostic fee might include an intake interview, social history, psychological examination, psychiatric and/or neurological examination, staffing of the case, and a completion interview with the parent or patient to discuss the findings and recommendations. If the patient then continues in regular treatment sessions, he is charged on a per visit basis. Currently, three of the eight centers use the single fee for diagnostic services. The remaining five centers charge a fee for each diagnostic visit. Of these five centers all report that the charge per visit for diagnostic service remains the same regardless of the discipline doing the service; for example, the fee for the social history is the same for a psychological examination or psychiatric examination.

Four of the centers offer some form of group therapy, to children or adults or to both. Of these four centers offering such service, three charge the same fees for group therapy sessions as for individual sessions and the fourth center charges a lower fee for group therapy. All eight centers report that the treatment fee remains the same regardless of which discipline is offering the treatment service.

Since all centers base their fees on income and size of family, several questions are raised as to what consideration was given to the frequency of treatment interviews and to the number of people receiving treatment in a given family when the schedule was established. For example, in establishing the schedule was it assumed that this treatment fee would cover one interview a week? If so, what fee would be expected if the treatment plan necessitated two or more interviews each week? Also, was it assumed that this assigned fee would be based on treating only one person in the family, and if so, what would the fee be if more than one family member were involved in treatment? As reflected in the actual practices of the centers, there are various methods of "proportioning" the cost. Specific examples are as follows:

Center III reports that parents and child are treated as one unit and that the assigned treatment fee applies to the treatment of the child, the parents or both.

Center II reports that if two or more family members are seen for treatment the initial fee is divided by the number of family members being seen and this becomes the fee for the individual family member.

Center IV reports that if a patient is seen more than once each week the treatment fee per interview is determined by dividing the original fee by the number of interviews recommended weekly.

Center II reports that if a patient is seen more than once per week the treatment

fee for the second interview is prorated. For example, if the fee for one visit a week is $3.00 the cost for two interviews a week would be $4.50.

As can be seen, there is considerable diversity in the method of prorating fees by the various centers but all of them have some plan which considers the frequency of treatment interviews and the number of family members receiving treatment.

The executive directors agree that the method and timing of the discussion of fees with the new patient has considerable significance in relation to the patients' willingness to accept their obligation to pay the assigned fee. The directors also express the opinion that the feelings and attitudes of the staff person in regard to charging fees is often reflected in the patients' attitudes and feelings about the fee system. In two of the eight centers, the family income and size of the family is ascertained by the clinic secretary, who then informs the patient of the cost of service. Most questions and comments received by the secretary are referred to the social worker who discusses these matters and the fee policy at the time of the patient's first visit. In the remaining six centers, the income, size of family and other items related to the fee policy are discussed initially with a professional staff person, usually the psychiatric social worker, at the time of the patient's first visit. Centers using this policy report that the discussion of money and fees often has diagnostic and therapeutic implications which are best handled by a professional staff member.

Most centers encourage patients to pay after each interview; the decision, however, to pay at the time of the visit or to pay in response to monthly billing is left to the patient. In most instances when a person in treatment is remiss about paying, the therapist, made aware of this by the secretary or bookkeeper, handles the situation directly with the patient as a part of the total therapeutic problem.

In instances where the diagnostic and/or treatment service has been completed and the patient has not paid his fees, various methods of collection are being used. To illustrate these methods, Center II sends a form letter after two months of non-payment. Center III has a series of six different letters sent at intervals, the first three months of non-payment. Three centers report they have no formal policy or procedure for attempting to collect unpaid bills.

In considering service given to another health or welfare agency, there is variance as to whether the agency requesting this service for their client is or is not charged. In response to the question "Do you charge a fee to other agencies, both public and private, for diagnostic service to their clients referred only for diagnosis?" three centers report that they do charge the agency. Five centers report that they make no charge to the agency requesting this diagnostic service nor do they make any charge to the referred client. They do, however, charge a fee to this client, based on the center's schedule, if he is subsequently seen for continuous therapy.

The primary reason for not charging other agencies for diagnostic or consultant service appears to be primarily related to the centers' sources of financial support. The centers which do not charge other agencies state that part of their budget is procured from public tax funds and Community Chest funds so that the center is obligated to give this service free to the tax-supported agencies and to other Chest-supported agencies.

In both the professional literature and in practice there has been considerable dis-

cussion of the therapeutic implications of charging a fee. In an attempt to see how this theoretical consideration could be related to the reality situations of those with marginal incomes, specifically those who are recipients of a public assistance program, the centers were asked if fees were charged to persons receiving public assistance, such as aid to dependent children. Five of the eight centers reported they never charged these people for service. One center reported it encouraged the public assistance recipient to pay a minimum token fee for diagnostic service but no fee for treatment service. The remaining two centers reported that fees were charged to this economic group "only rarely." One of these latter centers reported the fee might be as low as 25¢, but the other center expressed the belief that the 25¢ fee has little value today and that it felt that the minimum fee should be $1.00 and that service should be given free if the person could not afford this minimum. None of the centers refuse service to low-income families who cannot pay for service.

While the centers uniformly accept low-income families who cannot pay for service, there is considerable variation in their practice of accepting the upper-income families. Two of the eight centers limit their service to families of specified incomes. Center I limits its service to those with an annual family income under $5,000 although consideration is given to the size of the family. Center II limits its service to the following: single men and women whose income is under $3,000; a family of two (husband and wife) whose combined incomes are under $4,000; a family of three individuals whose income is under $4,500; and a family of four whose income is under $5,000. Thus, in both Center I and Center II the maximum family income which allows eligibility for service is approximately $5,000. Several reasons are stated to explain the practice of excluding from service those families whose incomes are over $5,000. Center I states their function is to provide low-cost psychiatric service only to people who cannot afford private care, assuming that families with an income of $5,000 can afford the private psychiatric care which is available. Although it does not see adults whose family income exceeds $5,000, Center II offers service to the pre-adolescent child regardless of the family income because there are no other facilities available in the community for treating a child this age.

The remaining six centers offer service to individuals of all income groups who otherwise are eligible for service. In these centers, when comparable private facilities are available for the treatment of children and adults, the typical practice is to inform the patient of these private resources and encourage him to use them, but the final choice of the facility to be used is considered the prerogative of the patient. The centers state that they do not wish to compete with private practitioners of psychiatry, psychology and psychiatric social work, and they charge fees to the upper-income patient which are comparable to the cost of private care. It is the centers' belief that charging patients who could afford private care eliminates those choosing the treatment facility on the basis of least expense. Two principal reasons are given as underlying the philosophy of not limiting services to patients of a specific income. One frequently stated reason is that in the respective communities comparable treatment facilities (which can be defined only in terms of the specific needs of individual cases) do not exist. Another frequently expressed interpretation is that

community clinics are intended to serve an entire community regardless of race, religion or economic circumstances and that people of upper incomes, who are helping support the centers through taxation and voluntary contributions, should have an opportunity to apply for service.

The directors of the centers are convinced of the need for flexibility in a fee schedule and recognize that the concept of fee charging is a fluid concept which needs continuous re-evaluation, study and revision to meet changing needs of the individual center, community and patient.

HANS A. ILLING

The therapist and the group evaluate

Evaluation and, with it, validation are the cornerstones of every science and the yardstick of its progress. Psychotherapists have often asked themselves what they and other practitioners were doing while treating patients individually or in groups. Among the many attempts that have been made to define the essence of group psychotherapy is Pederson-Krag's statement (1) that it is the "predominance of unconscious mental processes over conscious in a group"; Slavson's concepts of the essentials of evaluation—namely, transference, cartharsis, insight and reality-testing—are widely known (2).

The history of the evaluation of therapeutic groups is replete with studies and appraisals by many researchers, although few agencies or individual practitioners have sufficient time, energy and means, as well as adequate experience, to afford comprehensive investigations. Sometimes an evaluation may be made by an "outsider," such as an observer, supervisor or visitor (3). Then there are the opponents of group psychotherapy, whose arguments are based either on their lack of experience with groups or on their theories. Thus Jung feels (4) that a group can, under no circumstances, be of therapeutic value since it cannot be analytical and since the individual's growth and progress is being impeded by an increased suggestibility as well as by the pressure which the group exercises on the individual. Finally, there are the principles of the psychodramatic theatre and its methods in sociometry and sociatry as developed by Moreno, in which the group "evaluate" themselves through role-playing, there being no distinction between actor and onlooker. Trained "auxiliary egos" appear on the psychodramatic stage and the situations enacted concern sociological and psychopathological topics.

The writer is not concerned in this paper with the theory or practice of evaluative material *per se;* rather he will deal with an evaluation of an evaluation. In other words, he will attempt to evaluate the tensions, trials and tribulations consciously or unconsciously brought to the surface during an evaluative process.

Such an attempt to evaluate an evaluative process was made with different groups simultaneously. The individual parts of the evaluative process were collected by means of an interview form, which was based on Flanagan's research (5) and perfected by Bach.* Each form called for a few items of identification, such as the date, the age and the sex of the patient and the duration of therapeutic contacts in groups and/or individual sessions. The interview can take place between the patient questioned and the therapist either alone or in the group. The form is divided into two parts: Part I, designed for patients who are permanent members of the group, and Part II, designed for patients new to the group.

Part I contains the following 17 questions:

1. What is the name of the person who joined your group most recently?

2. How long ago did he/she join the group?

3. Describe some action of the new person that made a strong impression on you.

4. Describe some of the actions of the other members towards this new person.

5. Tell me exactly how you responded to this person when he/she was still new.

6. How did the therapist behave towards the new person at the time of the start?

7. What did you say to other members about this person?

8. What did you think about this person privately at that time?

9. What did you say to the therapist about this person?

10. Describe as exactly as possible in what way the coming of this person changed the group.

11. Who has been most helpful in making this new person feel at home in the group?

12. Why was this so helpful to the new member?

13. Who made things difficult?

14. Tell me exactly what these persons did that made it difficult for the new person?

15. Try to think of the first time this person appeared in one of your dreams.

16. As you think about this person now, what comes to your mind?

17. How old do you think is the new member?

Part II contains seven questions directed to the patient new in the group:

1. Now think of the time that you first came to the group. When was that? Approximate date. About how many meetings ago?

2. How did you react to the group when you were still new to it?

3. Who was most helpful in making you feel part of the group?

4. Tell me exactly what these persons did that was so helpful at that time.

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* The writer wishes to thank Dr. George R. Bach for permission to use his interview form with our groups. At present Dr. Bach (Beverly Hills, Calif.) is accumulating these forms for research purposes.

5. Who made life difficult for you in the group when you were new?

6. Tell me exactly what these persons did that made things difficult for you.

7. How did the therapist behave towards you when you first came to the group?

The form was used by this writer in various ways. To facilitate the tabulation of research data, the patients were first questioned individually. Since a majority of the patients in all groups reacted cooperatively but also mechanically and indifferently, and since a majority of them were also seen in individual sessions concurrently with their participation in group sessions, the writer submitted the same form to various groups as wholes a few months later, taking into consideration some changes in the groups. With the permission of the groups the writer read each question and had each member answer the therapist in the presence of the whole group, allowing for interplay and exchange of remarks. Thus it happened at various times with various members and with several questions that during an entire session only one question could be covered; at one session, not even one question was completed.

Generally speaking, the emotional content centering around the form, which all patients understood to be an evaluation, could be classified into three stages: (1) *anxiety,* precluding the member's speaking or acting out; (2) *catalysis,* involving catharsis brought about by the interaction of the group; and (3) *anticlimax,* indicating relief and readiness for more insight; or no progress in sight; or regression to the first stage with more and increased anxiety and longing for increased interdependence; or heightened suggestibility by the group (6–7–8).

Who were the groups? One consisted of three couples, all of them with psychosexual difficulties that led to marital problems; another consisted of seven teenagers of both sexes, all of them behavior problems to the schools and to their respective parents; and a third group were male inmates of an army disciplinary barracks (9–10). Let us elaborate on the three stages:

1. *Anxiety.* One of the most common symptoms in people awaiting a decision concerning themselves or someone close to them is anxiety. It can be called a normal state of affairs. It is therefore "normal" with patients, too. Any neurotic conflicts arising from anxiety, however, are revealed by the way in which patients deal with their anxiety; in this case, all patients were troubled about the unknown: (a) What is my score with the therapist? (b) What, after my score has been revealed through my answers to certain questions, will be my score with the group? (c) Will my score reveal progress, regression or nothing?

In the first group, only Part I of the form was discussed, since all members had started from the beginning and there had been no change in the structure of the group. It was significant, however, that husband and wife did not seem to support each other as much as the husband of one couple and the wife of another. Goethe would have called this situation *Wahlverwandtschaften.* There was, of course, anxiety; but it seemed to be sublimated, *i.e.,* mutually understood, accepted and even encouraged.

In the second group, the children reacted almost "normally," *i.e.,* full of curiosity, with some humor and juvenile spirit of adventure, much of which was cover-up of latent anxiety. It was the third group, the inmates, who demonstrated the most obvious symptoms of anxiety. For one, they

never felt completely at ease in the authoritative surroundings and tended to associate the therapist with them—even though they and he knew that he did not have any authority, being just a consultant in the institution. They expressed anxiety in various but usual ways, becoming extraordinarily verbal or argumentative or just being quiet and withdrawn. Some inmates felt as if they were before the Parole Board, even though they had been told that answering these questions (in fact, the discussion of the questions) was voluntary and could be refused altogether if the group objected to them. Their discussions as to what these questions might involve in the way of intrapsychic impact on their interdependent relationships seemed to be a prolonged prelude that took the form of acting out latent hostile feelings that had not been brought to the surface during previous sessions. If the therapist had stopped right there, *i.e.*, had not proceeded with the individual questions of the form, the discussion of the form would already have uncovered valuable material, analytical in nature and insight.

2. *Catalysis.* There was catharsis or catharsis-like acting out in all the groups. The groups' catalysis reached, as might be expected, different levels and degrees of intensity. In the first group, much of the catalysis was evidenced by arguments and counterarguments, each couple telling the other couple what they thought should have been the "right" answer, and each couple, answering a question directed to them, denying the other couple the ability to "know better." Although of the three groups the first was the closest knit, *i.e.*, knew each other best and each member felt "sympathetic" toward the other, the questions brought catalysis to a degree that tempers flared, angry words were exchanged, and the therapist felt that nothing could be gained by interpretation of unconscious conflicts resulting from questions which apparently had not much meaning to each member at this point. The therapist stopped the discussion of the questions, and the form was never completed.

The catalysis in the second group, perhaps due to the youth of its members, took a considerably milder form and showed quick forgetting, as is typical of children. Some of these children later related that it was "fun."

The third group, the inmates, was the only group with which both parts of the form were worked out. This group finished the entire set of questions and went through all the stages of catalysis. The inmates, as a whole, were the most cooperative (and the most submissive) group; they were, as already mentioned, always aware of the double father figure: the therapist in an authoritarian setting.

3. *Anticlimax.* The third group, the inmates, had, as a whole, the feeling of accomplishment after it was all done, just as if they had disposed successfully of a program of activities "prescribed" by the therapist. If some members believed that they had regressed, they did not wish to let on for reasons of group prestige, personal sensitivity and the wish to maintain their sense of belongingness.

The first group had been stopped in their discussion by the therapist. Except for one member (the most advanced in therapy prior to entering the group, and the most advanced in conversion hysteria), the group felt relief at being excused from making statements that seemed to get the individual deeper and deeper "in trouble" with other members; here, too, the therapist felt that gaining the sense of group belongingness held top priority in the minds of all members, including the special individual, who had wished to continue with

the questions to satisfy his masochistic impulses. In stopping the questions the therapist sensed that he was doing the group a favor, irrespective of therapeutic considerations.

As to the second group, the children, several of the girls felt a heightened sense of anxiety, from which they needed increased suggestion by the therapist and the other group members. On the whole, however, anticlimatic sensations were less apparent in the second group, compared to the others.

CONCLUSIONS

Unless a group has been stabilized, a questionnaire like the one presented can lead the therapist to lose control of the interplay, especially during catalysis, a period which is trying and in which the loss of control is often inevitable if extraneous matters are introduced. A form such as that outlined above should never be used in a group whose members are new and unstructured nor in one where the therapist has not had considerable experience in the practice of group psychotherapy.

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RABBI ROBERT L. KATZ

The role of the father

some psychological and religious views

We turn to religion for a vision of "what ought to be"; for the diagnosis and alleviation of specific difficulties and pathologies we turn to the therapeutic professions. But they too are concerned with more than the therapy of specific patients. All of us are concerned with parent education; many of us who are parents seek guiding principles and goals in family living above and beyond coping with today's or tomorrow's problems and crises; and as citizens we want the father to shape character and social responsibility in our children. Religion should contribute values of basic human interest. At the same time it can borrow from psychoanalysis as it tries to understand the affective components, the emotional realities which its long cherished ideals and insights symbolize and dramatize. We need a two-way passage between religion and psychiatry. As religionists we often keep alive our religious symbols and preserve our religious insights, content to repeat forms and rituals. We do this even after having lost the key to their basic meaning for the individual who waits for church to help him find answers here and now.

Although relations between religion and psychiatry currently are taking a turn for the better, we still use stereotypes and fail to appreciate that profound changes have taken place in both the theology and the institutions of modern religion. Freud created his own categories of religion: it was authoritarian, escapist, a kind of mass neurosis. He dismissed liberal religion as no-religion and admits in his *Civilization*

Rabbi Katz delivered this paper at an Institute on Religion and Psychiatry in St. Louis, October 5, 1956 at Temple Shaare Emeth.

and its Discontents[1] that "in my *Future of an Illusion,* I was concerned much less with the deepest sources of religious feeling than with what the ordinary man understands by his religion." Many religionists share with Freud a distaste for antiquated conceptions of an autocratic deity, agreeing with his opinion, as expressed in *The Future of an Illusion,* that "culture incurs a greater danger by maintaining its present attitude to religion than by relinquishing it."[2] Freud's fear that men would be coerced into submission by religious dogma and reduced to helpless dependence on all-powerful authority has been only partly justified. But modern religion does not keep man in chains. In our society other forces deny him freedom.

Freud's discussion of the father symbol and the role of authority in the family and in society hardly represent the realities of American family and religious life today. At the very core of our discussion of the role of the father is the question: "Where has the authority of the father gone?" Or the question: "What kind of fatherly authority is needed by the child and what means have we in our new type of democratic, non-authoritarian society for strengthening father for his indispensable tasks?" No longer does the father sit at the head of the American middle-class table as a patriarch-priest, symbolizing a rigid code, commanding obedience or reverence as the human, everyday counterpart to an all-powerful deity. At his best, dad or pop is the captain of the team. Sometimes he is cast in the role of a grey-haired sibling. Less jealous for the authority and responsibility of his office than for the freedom and self-expression of his children, the modern father chafes under the burden of his increasing years, envies the youth of his children, and struggles to remain their peer. The home itself is no longer the castle presided over by the king and judge. The historic fatherly roles have been taken over by other agencies. As Max Horkheimer wrote of the child in his *Eclipse of Reason,*[3] "He continuously responds to what he perceives about him, not only consciously but with his whole being, emulating the traits and attitudes represented by all the collectivities that enmesh him—his play group, his classmates, his athletic team, and all the other groups that, as has been pointed out, enforce a more strict conformity, a more radical surrender through complete assimilation, than any father or teacher of the nineteenth century could impose."

Like the home and the father, the church and the spiritual leader or "father figure" of the congregation have changed. American middle-class religion shows signs of a religious revival but this is more architectural than spiritual. Although here and there truly self-conscious individuals look for religious values and show an interest in theology that would have been unthinkable in the twenties or the thirties, American religious life is formal and socially respectable to a fault. It lacks depth of conviction and its leaders rarely command respect as symbols of unconditioned and transcendent truth. Where is the tyranny of religion over the minds of men? Who today hears of the war of science and religion? Cordiality towards the minister and attendance at church or temple on special occasions are almost indices of middle-class respectability, of thorough conformity to the prevailing pattern of a secularized religion. It is but one of many easily harmonized expressions of the American way of life. The modern pastor or rabbi no longer evokes fear of repressive

[1] London, Hogarth Press, 1953, 23.

[2] London, Hogarth Press, 1928, 62.

[3] New York, Oxford University Press, 1947, 141.

authority. Like the American father, he is more of the "pal" and the "brother figure." To be sure, this new role might afford more opportunities for empathy than the forbidding and aloof minister of yesterday but too often the minister himself responds to the same cues as does the layman. He avoids taking stands that would damage the popularity of the pulpit. This is not a weakness of individuals but a fault of our age which enforces anxiety over disapproval. The congregation is no longer fluent in the biblical sources and rarely is gripped by a feeling of awe and wonderment in the presence of God. The older traditions of a God of judgment hardly touch the feelings of the well-adjusted middle-class Jew or Christian. He has fears but he fears different objects from the older father symbols.

Even if the picture has been overdrawn, it is clear that familiar and religious symbols have lost much of their force. We must therefore reexamine the role of the father, keeping in mind that many of Freud's strictures about the repressive qualities of the earthly and divine fathers are not so pertinent as before. The power of the father has been broken. But we ourselves must still learn how to be fathers and to fulfill many of the functions traditionally assigned to the father. We have so long protested the abuses of fatherly authority and we are so imbued with the traumas of the father-son relationship that we have been all too prone to neglect its creative and necessary side. In psychiatric literature too, particularly the popular kind that is so much a part of our psychology-centered culture, the fatherly role has been greatly overshadowed by the motherly role and the stress on the emotional security of good mother-child relationships.

Our theme of the importance of the father in the shaping of character and in the child's preparation for the task of leaving his own parents to become a parent, a citizen and an individual in his own right and in his unique individuality is illustrated frequently in the Bible and other religious sources. There we can find, alongside passages stressing patriarchal authority, a model of the father as a teacher and as an agent of blessing. He is in religious language a model and a force helping each child to fulfill himself and to achieve a sense of identity. The importance of such a value in the fatherly role today is underscored by Erik H. Erikson. In his *Childhood and Society*[4] he takes cognizance of the changes in the needs of our day and those of Freud's. The problem is not the overthrowing of a repressive authority but the discovery of a way of living and of achieving an identity. Erikson writes: "The patient of today suffers most under the problem of what he should believe in and who he should—or, indeed, might—be or become; while the patient of early psychoanalysis suffered most under inhibitions which prevented him from being what and who he thought he knew he was."

Dr. Erikson adds, to the statement quoted above, that men today recover the lost patriarchal relationship in an attachment to the psychoanalyst. He writes: "In this country especially, adult patients and the parents of prospective child patients hope to find in the psychoanalytic system a refuge from the discontinuities of existence, a regression and a return to a more patriarchal one-to-one relationship."

A religious view holds out the possibility of the father's combining authority and love. It emphasizes his role in helping the child to achieve a sense of integrity and individuality at the same time that he

[4] New York, Norton, 1950, 239.

learns how to participate in the community. There is no irreconcilable conflict between these two goals. The good father is the symbol, the embodiment of this type of personality. He gives to his son an example to follow, he is the father and the teacher, to use an oft-repeated phrase of Talmudic literature. He is not cast one-sidedly in the role of one who frustrates and stands in the way of the child who knows what he wants to be. He is a necessary part, an asset rather than a liability in that process by which the child comes to learn what he wants to be. Psychoanalysis too asserts that the child makes a temporary identification with the father and thus takes the first step towards becoming familiar with the masculine adult role. Our religious sources do not make these unconscious processes explicit but they imply the strategic importance of the father as a moral teacher, a guide who helps the child achieve his humanity.

There is a confidence and optimism about parent-child relationships in the Biblical sources. This contrasts strongly with the more pessimistic themes in the Greek plays that Freud used to illustrate his theories of the father-son relationship. In the Greco-Freudian view of family life the competition of father and son was stressed. While so-called normal people succeed in passing through the oedipal period without excessive scars and patients liberate themselves through the analytic relationship from crippling conflicts over the issues of authority *vs.* individuality and freedom, son and father in the religious view have a more creative, harmonious and less hazardous relationship. Just as the Biblical view, at least the Hebraic view, of man is far more affirmative and hopeful than the fatalism of the Greek view so congenial to Freud, so the father is viewed as the one who teaches and blesses his sons. The father occupies a position of dignity and respect. Children, according to the fifth commandment, are bidden to honor their parents, for the elders stand almost in the place of God (Kiddushin 30b). A Talmudic source reads: "Our rabbis taught: there are three partners in man, the Holy One blessed be He, the father and the mother. When a man honors his father and his mother, the Holy One blessed be He says, 'I ascribe (merit) to them as though I had dwelt among them and they had honored Me.'" Now it might be thought that God was invoked merely as an ally for the parents in the inevitable and pitiless struggle for power between the young and the old. The Oedipus cycle of plays would have us believe that there is a blind instinctual struggle which is inevitable in the nature of man. Freud himself used the phrase "man is wolf to man." In his world-view the struggle between *eros* and *thanatos* was evenly matched with the edge given to the latter. In Judaism, the presence of destructive forces in man was fully recognized but love was destined to triumph because this was God's will and man was fully capable of living up to his own potentialities, as a child of one God, a partner with Him in the work of creation.

Religion does not feel that the arbitration of a power struggle between the father and the child is the central issue. It is not a compromise that is sought but a relationship of love and responsibility. The contrast between the Hellenic and the Hebraic views on the parent-child relationship was pointed up by the late Dr. Erich Wellisch in his *Isaac and Oedipus.*[5] The Oedipus myth ends in parricide. In the Biblical story, Abraham, about to offer his son Isaac as a sacrifice, withholds the knife. Abraham and Isaac, father and son, are henceforth

[5] London, Routledge & Kegan Paul, 1954, 90.

bound together in a covenant of love. The theme is one of love triumphant over competition and fear. To quote Wellisch: "The amplification of Abraham's object-love was directed to Isaac in the first place but embraced all human beings and, because of the promise attached to the call, even future generations. It was a love which aimed at the happiness of all mankind in a purified and redeemed world. This mental attitude is *messianic* love. It became the most dynamic moral power of Judaism and Christianity with widespread cultural effects."

In seeking the Biblical model of the father figure, we find in Abraham—called in Jewish tradition *avinu*—our father, the prototype of the moral teacher, the man who blessed his sons, the pioneer first to grasp the reality of the One God, the friend of God, the champion of justice.

Biblical literature reflects a patriarchal system; it no doubt enhanced a family system where fatherly authority was absolute. The laws concerning the rebellious son, Jephthah's sacrifice of his daughter, the presence of legal codes, obedience to which was enforced by an uncompromising Divine King whose power was absolute—these authoritarian themes are of course to be found in Biblical literature, but far more relevant to our needs and far more congenial to our views are other glimpses of a loving and compassionate Father in Heaven.

There are frequent comparisons between God who chastens his people out of His love and the father who chastises the son. In Proverbs 3.16 we read: "For whom the Lord loveth, he correcteth even as a father the son in whom he delighteth."[6] In the prophetic literature God the Father chastens His people out of compassionate love. In Jeremiah 31.20 we read: "Is Ephraim a darling son unto Me? Is he a child that is dandled? For as often as I speak of him I do earnestly remember him still: Therefore My heart yearneth for him, I will surely have compassion upon him, saith the Lord." The same fatherly endearments were voiced in Hosea 11.3: "And I, I taught Ephraim to walk, taking them by their arms; but they knew not that I healed them." In Psalms 103.13 the pity of a father for his child is taken as a symbol of the father-son relationship: "As a father pities his children, so the Lord pities those who fear him." A father's identification with his son appears in the words of David, mourning for Absalom (2 Samuel 19.1): "O my son Absalom, my son, my son Absalom, would I had died for thee, O Absalom, my son, my son."

The role of the father as teacher frequently appears in the book of Proverbs in such well-known verses as 22.6, "Train up a child in the way he should go, and even when he is old, he will not depart from it," and 13.24, "He that spareth the rod hateth his son; but he that loveth him chasteneth him betimes." We are reminded of the values of the father's teachings by the statement: "My son, keep the commandment of thy father and forsake not the law of thy mother. When thou walkest it shall lead thee; when thou sleepest it shall watch over thee and when thou awakest, it shall talk with thee." The prophet Isaiah (54.13) wrote: "And all they children shall be taught of the Lord; and great shall be the peace of thy children." Other verses, such as those in Deuteronomy, where the commandment to teach one's sons follows the call to love God with all one's heart (Deuteronomy 6.4) remind us of the role of the father as a teacher of morality as early as Biblical times. Part of the process of education is to gain a feeling of rever-

[6] Also Deuteronomy 8.5.

ence and awe for one's parents. With our contemporary appreciation of the role of family life as a possible breeding ground for neurotic conflict and for juvenile delinquency, we can appreciate the power of the statement in Malachi 3.23: "Behold I will send you Elijah the prophet before the coming of the great and terrible day of the Lord. And he shall turn the heart of the fathers to the children and the heart of the children to their fathers. Lest I come and smite the land with utter destruction."

Of particular interest to us in our preoccupation with the authority of the father are such passages as the fifth commandment (Exodus 20.12) dealing with filial piety, the admonition in Exodus 21.17 against cursing one's parent or in Leviticus 19.3: "Every man, his mother and his father, ye shall fear." In Jewish teaching, filial piety is closely associated with the will of God. Parents must teach the child a moral code which is binding upon both. The Hebrew word for "honoring" which appears in the fifth commandment is the same word that is used to designate the glory or the power of God. It represents the *schechinah* or divine radiance. Not mere submission to arbitrary human authority is demanded but acceptance and loyalty to the moral code and to the will of God. Of the more authoritarian passages we might cite Exodus 34.17 with its description of God visiting the iniquity of the fathers upon the children, a reference preceded, incidentally, with the words "merciful and gracious." That children shall not be punished for the sins of the fathers is the well-known theme of Ezekiel 18.4.

Only passing reference can be made to post-Biblical literature dealing with the role of the father. A famous passage (Kiddushin 29a) lists the fatherly roles most explicitly: "The father is bound in respect of his son to circumcize him, redeem him, teach him Torah, take a wife for him, and teach him a craft. Some say to teach him to swim too." He is one who initiates him into the community, provides moral instruction, helps him to build his own family, and serves as a vocational counselor. He has duties *vis-a-vis* his daughter too. If he was not enjoined as strongly to teach the daughter, he was to help her towards her wifely and motherly roles. The rabbis based their view on Jeremiah 29.6 and commented on the phrase "give your daughters to husbands." How was this to be done? The daughter should "be dowered, clothed, and adorned, that men should eagerly desire her" (Kiddushin 30b). An elaborate system of education was specified in rabbinic lore but of special interest to us is the insight concerning the extraordinary value which accrues to the son who was taught by his father. "A son who learns from his father, it is as though he had received his instruction at Mount Sinai" (Kiddushin 30a). Parental instruction has all the vividness and immediacy of a direct revelation of God. We close these selections from religious sources with one of the noblest formulations of the father's role (Yebamoth 62b): "Our masters have taught: He who loves his wife as himself, and honors her more than himself; who leads his sons and daughters in the straight path, and marries them near their time of maturity, to his house, the words of Job (5.24) apply, 'Thou shalt know that thy tent is peace.'"

Since we are concerned with general religious values, we shall not describe the historic Jewish home and the patriarchal role of the Jewish father except to comment that the modern Jewish family tends to take on the coloration of the middle-class

American family and inherits the same role conflicts. The American Jewish family too needs to rediscover the role of the father as teacher, as responsible authority, as limit-setter and as a model for identification. Therese Benedek's description of the contemporary father [7] would apply to Jewish as well as non-Jewish fathers in our culture: "The personality of the father seems weaker now that it is not supported by tradition; actually at present it must be more elastic, more adaptable, and therefore stronger than it was in earlier periods, since he has to hold out without the traditional support and often under attack—for he may be exposed to the open competition of his wife and even to the criticism of his children."

That a strengthening of the role of the father is necessary for the child's emotional and moral development there is little doubt. We are also convinced by students of contemporary society, such as Dr. Fromm, that our generation is coerced by a social order which represses individuality, which makes marketability the supreme judge of values. If autocratic paternal authority is not the issue of our age as it was possibly of Freud's, the authority of the state and of the economy is as absolute and as destructive of individuality as the most tyrannical father. As Herbert Marcuse indicated, the father "restrained in the family and in his individual biological authority is resurrected, far more powerful, in the administration which preserves the life of society." [8]

How can we persuade our children to honor their father and their mother? How can we help the modern father realize that his fatherly responsibilities are more than biological. The rabbis taught that he who begets the child is not called father—only he who trains and raises up the child (Shemoth R. 46). Does this not mean that we are asking children to resist enormous pressures for conformity in a commodity-centered culture? Does this not mean that we are asking the father to give to the child that which he lacks in himself—a sense of identity, a sense of confidence in his own values, and a respect for his own integrity as a man who bears the image of the divine? The modern father is hard put to discover what it is that he himself wants to be. He is not content with the model that our culture today holds out for him. He himself suffers from what the great Protestant theologian Paul Tillich calls the "anxiety of doubt and meaninglessness." He therefore leaves it to the "expert"—the rabbi or the pastor to teach his children. He himself has given up, saying "Rabbi, I'm not religious but I want my children to have a religious education."

Religion provides us with truths and values about the fatherly responsibilities. Modern psychiatry and social science help diagnose the ills and needs of our time. Their discoveries help us recover our own respect for religious insights. The individual and the social order are the patients. But how shall the work of healing begin? We cannot restore family values in a vacuum nor can we neglect the individual in a program for social change. We cannot urge the parent and the child to concentrate on their private salvation, for there can be no salvation without a sense of community and without a wise reverence for the supreme father symbol—God.

A religious view, while not a program

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[7] "The Emotional Structure of the Family," in *The Family: Its Function and Destiny,* edited by Ruth Nanda Anshen. New York, Harper & Brothers, 1949, 222–23.

[8] *Eros and Civilization; A Philosophical Inquiry into Freud,* Boston, Beacon Press, 1955, 91–2.

for action, would remind us who are parents, teachers, healers and citizens of verities in whose defense we may never relax. Psychoanalysis unfailingly reminds us that without self-respect man is hopelessly divided against himself. We must help the child while he is still young and when the child in time becomes a father he continues to need encouragement. For such courage, we might turn to the ancient teaching which reminds man of his inviolable dignity as a child of God. According to the Mishnah (Sanhedrin 4.5) as interpreted by Kohler, man was created single that he might know that he forms a world for himself, and the whole creation must aid him in unfolding the divine image within himself.

DONALD A. LETON

An evaluation of group methods in mental hygiene

There is an increasing interest in education about the social and emotional aspects of child development. Parents, teachers and school administrators are seeking help with the problems of personal adjustment, which they are beginning to recognize more clearly. Counselors, teachers and psychologists are looking to the behavioral sciences —psychology, sociology and psychiatry— for new and improved methods of instruction and treatment.

In the last decade a developmental change in the field of mental hygiene seems to have occurred. The literature has always been replete with lists of do's and don'ts and with stated principles of mental hygiene. Although these have proved of certain value in the field of education there was something lacking that prevented their popular application.

Teachers continued to be faced with the problem of "how?" Because of a lack of instructional methods and materials, the principles and recommendations were not implemented in classroom activities. The educational psychologists and mental hygienists had assumed that a teacher who possessed a knowledge of the principles of mental hygiene would learn the skills, adopt the appropriate attitudes and develop the materials which were necessary to teach mental health successfully.

For some time now teachers and educators have given lip-service to the teaching objective: "the all-round development of the child." They seem to be at a loss,

This article is a summary of Dr. Leton's Ph.D. thesis, "An Evaluation of Certain Methods of Teaching Mental Hygiene," written under the direction of Dr. Willis E. Dugan at the University of Minnesota. Dr. Leton is now an assistant professor in the School of Education at the University of California at Los Angeles.

however, to carry this objective from the verbal level to the action level in the classroom.

Efforts are now being made to improve social and emotional learning through specific programs of mental hygiene. Since the introduction of preventive psychiatry materials, a variety of techniques have been prescribed for teaching mental health. Some of these have come from the field of education itself, others from clinical psychology, social group work, psychiatry and medicine. Until these recent developments in methodology, teachers who wished to help students toward a better understanding of themselves and others had no clearly defined method by which they might accomplish this goal. The task remains for educational research to test the application of these methods in experimental situations.

STATEMENT OF THE PROBLEM

The purpose of this experiment was to evaluate the effectiveness of certain representative methods of teaching mental hygiene under a uniform set of conditions and with standard instruments of appraisal. The four methods which came under consideration were the following: Bullis's (5, 6) human relations classes, mental hygiene movies (8, 14, 18), sociodrama and role-playing (9, 11, 12, 16, 17, 21), and hobby and crafts activities (19, 22, 23). Although these are not comprehensive of all the methodology in this field, they are somewhat representative. They are comparable in that all elicit group discussion on problems of personal adjustment through the use of stimulus materials and group activities. They are also distinct from each other in that they involve different teaching procedures and are based on different theories of personality, therapy and learning. A uniform set of conditions prevailed in evaluating these methods because all the experimental groups contained the same number of students, met for the same length of time and held the same number of meetings, and were guided by a common set of objectives and by counselors with comparable experience and training.

DESIGN AND PROCEDURES OF THE EXPERIMENT

The experiment was conducted for two consecutive years in four high schools in St. Paul, Minn. The Bell Adjustment Inventory (2) was administered to the ninth grade class at the four participating schools. Students who received a rating of unsatisfactory or very unsatisfactory on the total score were screened for the experiment. Using systematic sampling procedures we assigned thirteen students to each of the experimental and control groups from the pool provided by the screening instrument. The total investigation consisted of eight separate and independent experiments, and each experiment had its own experimental and control group.

Table I indicates the framework of the experiment.

A statistical test (critical ratio) of the proportions of students receiving deviant scores in each of the two years was carried out. It was found that the two years were comparable in this respect. It was also determined through the use of the chi-square test that the four schools were comparable in the proportions of students who received deviant scores on the Bell Inventory.

The School Inventory (3) and the Rogers Test of Personality Adjustment (20) were then administered as additional pre-tests. Attendance data and a numerical composite of grades for 1952–53 were also obtained. Ratings on a Social Distance Scale, adapted from Bogardus (4), were obtained from the

TABLE I

Framework of the experiment [1]

	NINTH GRADE 2ND SEMESTER 1952–53					NINTH GRADE 2ND SEMESTER 1953–54				
School	*method*	*Grade N*	*N*	N_1	N_2	*Method*	*Grade N*	*N*	N_1	N_2
1	Activity	236	48	13	13	Sociodrama	231	45	13	13
2	Bullis	254	52	13	13	Movies	259	43	13	13
3	Sociodrama	110	26	13	13	Activity	128	24	12	10 [2]
4	Movies	447	113	13	13	Bullis	322	72	13	13

[1] Grade N is the number of students in the ninth grade class, N is the number of students with deviant scores, N_1 is the experimental sample, and N_2 is the control sample.

[2] Two students from this control group dropped out of school before the experiment was completed.

experimental group at School 3 in the first meeting.

SELECTION AND TRAINING OF GROUP LEADERS

The selection of the group leaders in this experiment was made on the following basis:

1. They were known to have very good relationships with students, and were recommended by two or more administrators.

2. They had shown a previous interest in curriculum improvement by participating on committees and in professional organizations.

3. They had previous knowledge of or experience with the methods that were to be used in the experiment.

The writer then carried out an in-service training program with the group leaders:

1. To familiarize them with the particular methods that were to be used in the groups.

2. To define a common set of objectives that would be relevant to each of the four methods and acceptable to the groups.

3. To familiarize them with the theory and literature relating to these methods.

4. To give them practice in the use of Bullis's stories, sociodrama and tape recorders.

5. To familiarize them with movies and discussion techniques.

The training program consisted of four meetings and additional informal contacts in which the methods and materials were discussed.

Information about the group leaders' educational qualifications and work experiences was obtained. Their personal characteristics, attitudes and values were measured with the following tests: Minnesota Multiphasic Inventory (10), Minnesota Teacher Attitude Inventory (7) and Allport-Vernon Scale of Values (1). The data thus provided were not analyzed. If complete replications of methods and leaders would have been possible their differential effects could have been determined. Because of the group leaders' comparability in training and experience background it was assumed that they were comparable as treatment agents.

EXPERIMENTAL TREATMENTS

Weekly meetings were then held with each of the experimental groups for one semester during which the methods under consideration in this study were utilized. There were no special meetings for the students in the control groups, except for administration of pre-tests and post-tests. Beyond the in-service training program and the choice of methods and materials there were no further experimental controls over the group leaders.

The mental health discussion was directed toward a possible identification, understanding and amelioration of the unknown etiological factors which had disposed the students toward poor adjustment. The basic hypothesis in this experiment was that group techniques for mental health could produce demonstrable changes in the criteria of students' adjustment.

POST-TESTS AND OTHER EVALUATIVE DATA

The Bell Adjustment Inventory, the Rogers Test of Personality Adjustment and the School Inventory were administered to all groups. Attendance data and the numerical composite of current subject grades were obtained for 1952–53. Typescripts were made from tape recordings of the group at School 2 in 1952–53. The Social Distance Scale was readministered to the group at School 3. An Opinion Inventory was obtained for all students in experimental groups 1953–54 and at School 4 in 1952–53.

RESULTS ON ADJUSTMENT INVENTORIES

Hypothesis 1. There are no significant changes resultant to courses in mental hygiene on the following criteria of adjustment: the Bell Adjustment Inventory, the School Inventory and the Rogers Test of Personality Adjustment.

The analysis of variance technique compares the variation to which the experimental and the control groups were subject. If members of the experimental group show positive changes in their adjustment scores that are not also seen in the control groups, the results may be attributed to the educational treatments.

The analysis of covariance increases the precision of this experiment by eliminating the variation on the pre-test means.

Table II summarizes the findings from the analysis of variance and covariance on pre- and post-test means.

Conclusion: The findings from the analyses of variance and covariance were predominantly negative. Consistent changes in favor of the experimental post-test means were not observed.

Out of 48 analyses of pre- and post-test means there were only four that showed significant positive change and there were two instances in which the change was toward poorer adjustment. In 40 of the 48 analyses the null hypothesis was accepted.

EVALUATING SCHOOL ATTENDANCE AND GRADE DATA

Hypothesis 2. There are no significant differences between the experimental and control groups on the following behavioral data: School attendance; course grades.

Conclusion: One of the control groups received significantly better grades than did the experimental group. This was a reversal from the desired direction. One experimental group showed significantly better school attendance than its control group. The null hypothesis was accepted in six of the eight analyses.

EVALUATING STUDENTS' OPINIONS

An inventory of the students' opinions about the meetings was obtained for five of the eight groups. Positive, neutral and negative reactions were indicated by their choices from 36 statements about the group members, the leader, the activities and their experiences in the meetings.

Hypothesis 3. There is no difference between the observed distribution of students responses on the Opinion Inventory and a theoretical distribution which would occur by chance.

Conclusion: In analyzing the responses for the five groups we found that their opinions were predominantly favorable.

TABLE II

Summary of results of analyses of variance and covariance

YEAR AND SCHOOL	METHOD	F RATIOS FOR ANALYSIS OF VARIANCE		
		Bell	*School*	*Rogers*
1952–53				
1	Activities	<1.0 N.S.	10.01 S	<1.0 N.S.
2	Bullis'	1.3 N.S.	1.12 N.S.	<1.0 N.S.
3	Sociodrama	215.8 S.[1]	4.35 S	<1.0 N.S.
4	Movies	<1.0 N.S.	<1.0 N.S.	3.39 N.S.
1953–54				
1	Sociodrama	<1.0 N.S.	<1.0 N.S.	4.49 S.[2]
2	Movies	<1.0 N.S.	1.5 N.S.	3.0 N.S.
3	Activities	<1.0 N.S.	<1.0 N.S.	<1.0 N.S.
4	Bullis'	<1.0 N.S.	<1.0 N.S.	<1.0 N.S.
1952–53				
1	Activities	<1.0 N.S.	6.52 S	<1.0 N.S.
2	Bullis'	2.72 N.S.	1.49 N.S.	<1.0 N.S.
3	Sociodrama	113.0 S.[1]	4.17 N.S.	<1.0 N.S.
4	Movies	3.50 N.S.	5.84 S	3.24 N.S.
1953–54				
1	Sociodrama	<1.0 N.S.	<1.0 N.S.	5.08 S.[2]
2	Movies	<1.0 N.S.	1.32 N.S.	2.28 N.S.
3	Activities	<1.0 N.S.	1.47 N.S.	<1.0 N.S.
4	Bullis'	<1.0 N.S.	<1.0 N.S.	4.71 S.[2]

N.S. indicates that the differences between mean scores was not significant; S. indicates that mean differences existed.

[1] Indicates that variances were not homogeneous. Thus S may be an indication of unequal means or unequal means and variances.

[2] Indicates that the post-test scores for the experimental groups were significantly higher than for the control group, a reversal from the desired direction.

TABLE III

Summary of results of analyses of variance in grade and attendance data

YEAR AND SCHOOL	METHOD	F RATIOS	
		Attendance	*Grades*
1952–53			
1	Activities	3.18 N.S.	3.89 N.S.
2	Bullis'	1.85 N.S.	7.2 S.
3	Sociodrama	10.3 N.S.	1.65 N.S.
4	Movies	<1.0 N.S.	2.19 N.S.

TABLE IV

Distribution of opinion responses for five experimental groups

YEAR	SCHOOL	POSITIVE	NEUTRAL	NEGATIVE	TOTAL
1952–53	4	88	23	9	120
1953–54	1	84	56	16	156
1953–54	2	114	34	8	156
1953–54	3	92	19	9	120
1953–54	4	52	61	43	156
TOTAL		430	193	85	708

TABLE V

Chi-square test of agreement between the observed and the theoretical distribution of opinion responses

CATEGORY	OBSERVED FREQUENCY	THEORETICAL FREQUENCY	$\frac{(f_o-f_t)^2}{f_t}$
Positive	430	236	159.5
Neutral	193	236	7.8
Negative	85	236	96.6
TOTAL	708	708	$X^2 = 263.9$
			$P < .001$

TABLE VI

Extent of participation in discussion and improvement in adjustment scores

STUDENT NO.	1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement in Bell scores	52	37	7	27	32	15	3	17	15	8	15	20	12
Number of statements	13	132	30	67	40	6	66	30	29	30	26	60	68

Separate analyses were made for each of the five groups and it was found that the favorable opinions existed in all but one group, School 4, 1953–54. Many of the neutral statements were favorable in some respects, and this may account for the large number of neutral responses in several groups.

EVALUATING PARTICIPATION IN DISCUSSION

In determining the extent of participation in discussion the typescripts of the tape recordings for School 2, 1952–53 were analyzed. This is the only group for which these were available. A count was made of the number of statements by each student without regard for the length of the statement or the number of words spoken. This was accepted as a measure of the "verbal pressure" to participate. Table VI indicates the improvement in adjustment scores and the extent of participation in discussion.

Hypothesis 4. There is no significant relationship between the amount of improvement in adjustment scores and the extent of participation in group discussion.

The correlation coefficient between these two variables is found to be +.14. Utilizing the "t" test it was found that this relationship is not significantly greater than zero ($t=.47$, $.7>p>.6$). The null hypothesis was accepted.

EVALUATING SOCIAL ACCEPTANCE

The Social Distance Scale was designed to provide a quantitative measure of the acceptance which the group members held for each other. The initial and final mean ratings are shown in Table VII.

Conclusions: A "t" test of the mean differences was obtained ("t" $= 2.58$, $p < .05$). The null hypothesis was rejected, and it is concluded that the students in this human relations class showed a greater acceptance of their fellow members following their experiences in weekly meetings.

SUMMARY OF ANALYSES

There was a total of 56 analyses of variance and covariance problems on various criteria of adjustment. The null hypothesis of equal means was rejected in only six of these analyses. There was some indication that improvements in school adjustment and attendance data could be attributed to courses in mental health. The Bell Adjustment Inventory, the Rogers Test of Personality and school grades, however, did not reflect any significant improvements.

Two of the analyses which were made on

internal criteria were significantly positive. These analyses indicated the following:

1. The opinions of students who participate in discussion groups are predominantly favorable.
2. The students show a greater acceptance of each other following their experiences in discussion groups. The experimental findings in regard to these criteria appear to be significant; however, they do not provide conclusive evidence since comparable data was not obtainable for control groups. The analysis of the extent of discussion and changes in adjustment scores failed to show a significant relationship between these variables.

INTERPRETATION OF RESULTS

The burden of the proof of effectiveness for these mental health methods actually rested with the students, the group leaders and the test data. The inability of the group leaders or the students to effect change, or the inability of the test data to reflect such change, would produce non-significant results in this experiment. A critical step in research on mental health is the establishing of adequate criteria of effects.

Before there can be extensive research on the methodology in mental health the problem of training teachers and counselors must arise. This research was not designed to provide data on such training. The justification for any change or additions to the present training programs for teachers and counselors should be based on its value in terms of pupil adjustment and achievement. These values have not been demonstrated in the existing research.

The limitations that existed in this study were many, and they are obvious to most educational researchers. It is appropriate, however, to point out some of the important limitations. First, the length of the group meetings may not have been sufficient for the treatment effects to appear. Second, the instruments used may not have been sensitive to any changes which might have occurred. Third, many of the variables in regard to the group methods and the "treatment agents" were not controlled.

In future research on mental health an attempt should be made to measure the long-term effects of such programs. The transfer of social and emotional learning to life situations is another variable which should be considered.

Many of the principles evolved by group therapy and social group could be incorporated into teaching methods in the classroom. To create sufficient facilities for individual counseling and psychotherapy

TABLE VII

Initial and final mean ratings on the social distance scale

STUDENT	1	2	3	4	5	6	7	8	9	10	11	12	13
Initial mean	3.46	3.77	3.38	3.46	3.38	3.08	3.92	2.92	3.85	3.31	3.15	3.23	3.54
Final mean	3.69	3.69	3.08	3.54	3.46	3.38	4.08	3.15	3.92	3.38	3.38	3.85	3.92

seems at present to be an impossible task. It would be possible, however, to apply some of the practices evolved by group therapists for children whose personality difficulties have resulted in poor school adjustment. Modifications of social and clinical group work could also be incorporated into the school guidance program. Thus, schools can extend their efforts to work with problem children in several ways; however, such efforts should be under continuous and critical appraisal.

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Statistical surveys in the field of mental disorders

The need for reliable information about the numbers of patients being admitted to and discharged from mental hospitals and the incidence of mental disorders in the community has long been recognized. Pollock (21), describing the development of statistics of mental disease in the last century in the United States, points out that the problems of producing useful statistics were being commented on over 100 years ago. He quotes Dr. Isaac Ray, superintendent of the Butler Hospital for the Insane at Providence, R. I., who in 1840 suggested that ". . . to make our statistics profitable, they should embrace only such facts as are intrinsically important, and free from all admixture with mere opinion."

Reliable statistical data can help both the administrator and the psychiatrist. The administrator concerned with the provision of facilities for the care and treatment of the mentally ill needs to know the prevalence of mental illness in the community as well as the nature of the case load which will result. The psychiatrist hopes that such knowledge will throw light on the etiology of mental disorders, which in turn will help in the establishment of specific methods of treatment. Lemkau (15) has described the contribution that epidemiological studies of mental disorder can make to psychiatry.

PREVALENCE AND INCIDENCE

Two main methods of studying the prevalence of mental illness have been adopted. The first aims at a complete enumeration of all cases of mental illness in a defined population. The second assumes that those being treated for mental illness represent exactly the prevalence in the population. The first method, in spite of its inherent

Mrs. Wright and Dr. Ozarin are on the staff of the American Psychiatric Association's architectural study project. This study was made possible by a grant from the U. S. Public Health Service.

difficulties, remains attractive because of its essentially logical and exhaustive character.

Felix and Kramer, who have studied the problem of obtaining information essential to the planning of mental health services for many years, describe some of the difficulties encountered in this work (6): "Even before we can accurately determine the number of mentally ill in our population, we must first acquire the following kinds of basic knowledge: a clear definition of the entity we are trying to count; diagnostic methods which permit the separation of the population into those who have 'mental illness' and those who do not, and case-finding techniques that can be used to detect cases of the disease in representative samples of different segments of the population. These are necessary in order to estimate the general prevalence and incidence of the disease with some degree of accuracy and to study its differential distribution by race, sex, age, geographical location and so forth."

A number of attempts, both in this country and abroad, have been made to measure the total prevalence of mental disorders in small communities. Lemkau and others, with the support of a grant from the Rockefeller Foundation, made a survey of statistical surveys of this type. Their report (16), published in 1943, covered all major investigations completed and published in the previous 15 years. In it, they concluded that ". . . poor selection of sample populations and insufficient numbers of cases as well as differences in investigative methods, differences in fundamental concepts and differences in diagnosis and classification tend to make the available studies of mental disorder basically improbable."

The most complete studies of this type carried out in the United States were made in Eastern Baltimore (17) and Williamson County, Tenn. (24). Even in these there were differences in technique. In the Baltimore survey case-finding was carried out by searching the records of the various institutions and agencies whereas the material for the Tennessee study was partly reported by key members of the community and partly discovered by field workers who spent a long time in the community. In the latter study nearly all the cases were examined by a psychiatrist whereas none were in the former. Because of these differences in technique and because the areas were so unlike in character the results of the two surveys are not comparable. However, more of these studies have been initiated—some of them were described in 1952 at the annual conference of the Milbank Memorial Fund (14) and by Felix and Kramer (6)—and they should provide valuable information about the prevalence of mental disorder in different communities.

At present the most usual sources of information about the incidence of mental diseases are hospital records. One obvious disadvantage of information obtained from these sources is that it relates only to persons whose illness is sufficiently serious to warrant admission to hospitals, usually a long-stay hospital. Felix and Kramer (7) concede that such material does give reliable information about the numbers of patients admitted to the hospital, their age, sex and diagnosis, but draw attention to its limitations: "However, it is difficult to use hospital data to generalize about the prevalence and incidence of similar disorders in the general population. We lack a basic fact—the relationship between the number of persons hospitalized for a given disorder and the number of persons in the population with the same disorder who never reach a mental hospital. Hospitalization rates are a resultant not only of the true incidence of mental disorder but of a number of factors such as availability of mental hospital beds, public attitudes to-

ward hospitalization, and availability and use of other community resources for diagnosis and treatment (for example, general hospitals with psychiatric treatment services, psychiatric clinics and private psychiatrists)."

In fact, admissions to hospitals probably reflect provision rather than incidence and are known to increase as more facilities become available.

FIRST ADMISSIONS

Notwithstanding these limitations, the surveys which have been made of first admissions to mental hospitals comprise the greater part of our knowledge of mental disorders. The numbers of first admissions do give a moderately reliable index of incidence in those areas which have a long tradition of adequate provision of facilities for the care and treatment of the mentally ill. Fortunately Massachusetts and New York State, which have provided some of the most comprehensive statistics on mental disorders, have both had a history of attempting to serve the needs of the community.

One of the most impressive analyses of hospital admissions was that made by Dayton (2) of 89,190 cases admitted to mental hospitals in Massachusetts during the period 1917–33 inclusive. This study was not designed to give detailed information about individual patients and their treatment but to give a broad picture of the whole problem of mental disorder: "Rather than go behind the scenes and subject individual patients to the microscope, we choose to stand back and regard these 90,000 admissions to mental hospitals as one huge individual. . . . The fact of admission to a mental hospital will be considered, not as the beginning, but rather as the end result. From this point we retrace our steps and study certain common influences which affected all patients before their admission to a mental hospital."

The factors considered included age, sex, marital status, occupation, religion, ancestry, geographic location and diagnosis. An attempt was also made to correlate the numbers admitted with the degree of unemployment at that time and the economic conditions in the state.

Comprehensive analyses of the admissions to the state hospitals in New York State and Illinois are also available. One analysis of first admissions to the New York civil state hospitals covers the years 1919–21 and 1949–51 (19). Malzberg found that the rate of admission had increased more rapidly than the general population and that there had been a notable change in the age distribution of those admitted: "Next to the increase in absolute numbers, the change in the relative distribution of first admissions according to age is probably the most important difference between the 1919–21 and the 1949–51 periods. The median age for all first admissions increased from 40.5 years to 52.1 years."

The study of admissions to Illinois state hospitals (27) covered the period from July 1, 1922 to December 31, 1943 and like the New York study was concerned with trends. One of the most interesting findings was that there were definite and repeating patterns of seasonal variation in the admissions throughout the years: ". . . the low point in monthly admissions each year may be expected to occur in November, with a gradual rise in December and January, then followed by a substantial drop in February, after which the increase is steady until the peak in admissions is reached during June and July, and is again followed by a steady decrease to the low of November. This contour for a given year can be evidenced for any year in the study. . . ."

As in New York State, there was a considerable increase in the numbers of first admissions during the period, the rise being double the rise in the general population during the same period.

Since 1918, when the first attempts to collect standard statistics from all mental hospitals were made, the annual census statistics on patients in mental hospitals have become increasingly complete. The latest report (20) includes an analysis of first admissions to 188 state mental hospitals by age, sex and diagnosis. The essential usefulness of such statistics was described by Sheldon, who analyzed the census statistics for the period 1933–42 (26): "The census statistics on patients in mental hospitals are perhaps of maximum usefulness in providing an over-all frame of reference from which the results of more detailed and analytical studies can be generalized. A knowledge of the trends in mental disease for the country as a whole permits inferences as to the representative quality and general implications of the trends revealed in more detailed studies of state statistics."

He found that there had been an increase in first admissions for the country as a whole paralleling those found in the states of Illinois and New York, but attributed this increase to the increasing numbers in the older age groups of the population. Dorn writing in 1938 (3), comments: ". . . it means that most of the increase may be attributed to increase in the expectation of life, an increasing proportion of old people in the population, increasing urbanization and similar environmental factors."

Goldhammer and Marshall (9) studied the first admissions for the years 1840–85 to institutions for the care of the mentally ill in Massachusetts and compared the age specific rates with those of the present day. They concluded that: "When appropriate comparisons are made which equate the class of patient received and the conditions affecting hospitalization of the mentally ill, age specific first admission rates for ages under 50 are revealed to be just as high during the last half of the 19th century as they are today."

However, they did find that there had been a marked increase in the age specific rates in the older age groups, which may partly reflect a real increase and partly an "increased tendency to hospitalize persons suffering from mental diseases of the senium."

These results have been substantiated by the results of a study made in Ontario by Wanklin and others (28), who found that when the first admission rates to mental hospitals for the years 1927–46 were standardized against age, the only considerable increase was in the admission rates for the older age groups.

The preceding discussion of first admissions has been primarily concerned with their use as measures of the extent of mental disorders. Many of these studies also add considerably to our knowledge of mental disorder by establishing correlations between admission rates and other factors. For example, the differences in incidence of the various mental disorders at different ages are well established. Malzberg in his analyses of first admissions to the New York civil state hospitals (18) points out that diagnoses must be related to age and sex: "It has been shown that the probability of a mental disorder, as measured by rates of first admissions to hospitals for mental disease, varies directly with age, being low in childhood and advancing to a maximum in old age. However, this trend is characteristic only of mental disorders as a whole. Individual groups of mental disorders appear at different ages, reach maximum rates of prevalence at different ages, and decline in incidence at varying rates."

One of the earliest attempts to correlate the incidence of mental disease with particular social conditions was made by Faris and Dunham (5) in their ecological study of mental disease in Chicago. They examined the distribution of the residence of patients admitted to mental hospitals with major psychoses and found that the rates showed a regular decrease from the center of the city to the periphery. They also found that each of the major psychoses had a characteristic distribution with respect to the different areas in the city. Thus higher rates of schizophrenia were associated with the unfavorable economic and social conditions in the center of the city, and higher rates of manic depression tended to be associated with higher rental areas.

Schroeder (25) compared these results with those of studies made in five other cities—Kansas City, Milwaukee, Omaha, St. Louis and Peoria. He found that these studies "tend to verify the findings of Faris and Dunham, more completely for total rates than for rates by specific psychosis." Because the numbers of cases in these five studies were so much smaller than in the Chicago study it was not possible to substantiate the findings of Faris and Dunham on the distribution of particular disorders.

More recently Wanklin and others (29), analyzing the factors influencing the rate of first admissions to mental hospitals, found that: "Higher rates tended to be associated with urban residence; with single, divorced and separated marital status; with lack of more than eight years of schooling, and with recent immigration among the foreign-born."

DISPOSITION

Numerous other studies have been carried out with more specific aims in view, and in general they represent attempts to measure increases in therapeutic effectiveness. Notable examples are the historical study of disposition of first admissions to Warren State Hospital (13) and the 5-year follow-up study of patients committed to the Boston Psychopathic Hospital (1).

The historical study of the disposition of first admissions to Warren State Hospital was carried out in cooperation with the National Institute of Mental Health "in an attempt to unravel some of the problems associated with obtaining meaningful measures of the rate at which patients are separated from the hospital."

This study was the immediate consequence of an article by Israel and Johnson (11) in which they drew attention to the need for "the standardization of a new type of statistical analysis which will portray accurately both to the medical profession and to the public the true facts of prognosis in mental disease and the progress which has been made in therapy." They pointed out that the figures relating to total hospital populations were primarily concerned with the accumulation of chronic patients and gave a false impression of the prognosis for new patients.

The study of admissions to Warren State Hospital included all patients admitted for the first time during four consecutive periods in the years 1916–50. The study had the definite objective of recording how many patients were released to the community, how many died in the hosiptal and how many remained in the hospital. Unlike the studies described previously, this was a cohort study. Members of each cohort were followed for the same periods of time so that differences in prognosis in the different periods could be measured precisely and separately. The four periods 1916–25, 1926–35, 1936–45 and 1946–50 were chosen because they coincided with

events which might have affected the treatment of patients. For example, during the period 1926–35 the hospital began to lay great stress on occupational and industrial therapy; in the period 1936–45 increasing use was made of the various shock therapies. The results of the study showed that "the proportion retained continuously has decreased from the earliest period to the present." Of those admitted during the 1916–25 period 39% remained in hospital continuously as compared with 28% of those admitted during the 1946–50 period. There was an increase in the number of first admissions from one decade to the next as well as an increase in the probability of release. Although various therapies were used in increasing volume in the later years the authors were cautious in assuming that this factor alone is responsible for the better prognosis in the later periods.

In contradistinction to this historical study, the 5-year follow-up study of 100 patients admitted to the Boston Psychopathic Hospital concerned patients admitted consecutively after July 1, 1946. Of these 100 patients 70 were discharged to the community. At the end of five years 76 patients, some of whom had been transferred to other mental hospitals from the Psychopathic Hospital, were in the community. Israel and Johnson (11) also found that 70% of all first admissions during 1940–42 exclusive of those admitted with senile psychosis and psychosis with arteriosclerosis (these groups were also excluded from the Boston study) were discharged to the community.

Frankel's study of 4,611 patients admitted to three state hospitals in New Jersey during the three years 1944–46 was also addressed to the assessment of treatment results (8). In relation to every 100 of the 4,611 patients admitted for psychoses diagnosed as involutional, manic depressive, dementia praecox, paranoia and paranoid conditions, and for psychoneurosis and psychopathic personality, 74 patients were discharged.

Perhaps one of the most unexpected findings of these studies relates to the schizophrenic disorders, which are generally thought to have a poor prognosis. Bockoven comments that "more than three-quarters of the schizophrenic patients were in the community five years after admission, having spent an average of less than eight months in a mental hospital." Frankel, analyzing the outcome of treatment at three state hospitals in New Jersey, found that 60% of the schizophrenic patients were discharged to the community.

DISCUSSION

There is a considerable amount of information relating to the occurrence of mental disorder; Gruenberg has reviewed the literature and compiled a bibliography of 362 references (10). Admissions to mental hospitals have been analyzed by age, sex and diagnosis, and the relationship of the incidence of mental disorder to various social and economic factors has been studied.

Dunham (4) has described some of the difficulties encountered when attempts are made to discover the distribution of mental cases in particular geographical areas. In all studies of mental disorder in communities there is the problem of defining what shall be considered a case of mental disorder and then the problem of finding these cases. Until methods of solving these problems are evolved the data obtained from studies made in different areas by different people will not be strictly comparable.

Felix and Kramer (22 and 23) have drawn attention to the differences between states in the distribution of the various diagnoses among first admissions to mental hospitals. They have suggested that these

differences may result from differences in the methods of reporting and from differences in definition rather than from any real variations in incidence. For example, in one state the term *first admission* may mean the first admission to any hospital for the care and treatment of the mentally ill and in another state it may mean first admission to that particular hospital. Differences in the type of facilities available in different areas may also account for some of the differences.

Many of these problems will disappear as methods of reporting statistics become uniform. At present 18 states are included in the model reporting area and produce tabulations agreed on jointly by the National Institute of Mental Health and the participating states.

Proper planning of mental health services demands a knowledge of whether or not mental disorders are increasing. At present there is no agreement on this point. Changes in methods of classifying mental disorders, changes in population structure, changes in treatment, and changes in the public attitudes toward mental hospitals are among the factors which have to be considered whenever comparisons are made of measurements taken at different points in time.

CONCLUSION

The need for more studies of the disposition of patients from mental hospitals, similar to Israel and Johnson's study of 4,254 consecutive admissions of schizophrenia (12), is obvious. Ultimately the efficacy of hospital treatment can be assessed only by the numbers of patients who after treatment are able to live in the community. To do this, comprehensive follow-up studies of admitted patients are urgently required. Precise estimates, for any group of admitted patients, of the number likely to be discharged, their probable length of stay in the hospital and their chances of being readmitted would be an invaluable administrative tool.[1]

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Promoting effective relationships between the school and the child guidance clinic

It is the intent of this paper to suggest ways and means of increasing the cooperation between the child guidance clinic staff and school personnel, to point out some of the difficulties involved and to focus specifically upon the improvement of the clinic-school conference.

In many communities the clinic staff offers its services to the school on request and gives talks to groups of teachers and to PTA organizations. Less often the clinic offers consultation services for teachers and in-service workshops for school personnel. Too often communication and cooperation between school and clinic come about only after a crisis has occurred and a conference is called as a last resort. This may happen when the clinic feels that its efforts are being defeated by the activities of the school as represented by a particular teacher or when through a mother's insistent efforts therapist and teacher finally get together or when a teacher notifies the clinic that a child is about to be expelled from school and asks for help. But a conference held under these rather forced and hurried circumstances does not have the foundation upon which real cooperation is based.

Although the school and the clinic approach the child in different ways, the end they serve is the same—the welfare of the child. It is not only logical but essential that the two join forces and coordinate their efforts toward the common goal. It is essential too that the coordination of ef-

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fort should come early in the treatment of the child. This requires that the therapist contact the teacher as soon as possible after treatment plans are set up and the parents' permission is obtained. With difficult children the teacher needs the help that the therapist is in a position to furnish. The therapist needs the information and the impressions that the teacher has acquired through her efforts with the child and with the parents. In other words, it is a reciprocal relationship that both teacher and therapist need if their work is to be most effective. Then too the clinic staff needs to keep in mind always that when their work is "through" it is the teacher who is the key figure (of course, along with the parents) in the further growth of the child.

Let us consider some of the reasons for lack of cooperation between clinic and school; some of the responsibility rests with the clinic staff and some with school personnel:

1. The teacher and the school administrator are frequently unaware or ill-informed about clinic procedures, and they have no real grasp of what treatment is.

2. Sometimes there may be strong negative feelings about working with an unfamiliar profession.

3. The teacher may be hesitant about getting involved in a personal way with people associated with psychiatry or be unduly sensitized because of some problems of her own.

4. The teacher may be reluctant to contact the clinic because to do so would be to admit failure and lead to feelings of guilt and self-condemnation. In this regard, she may also fear the criticism of the principal and of her fellow-teachers.

5. Then too the clinic is frequently viewed as a last resort and a kind of dumping-ground for the hopeless cases, the process of referral being tantamount to a discharge of responsibility and of involvement with the particular child.

6. The teacher may hesitate to make a referral to the clinic for fear of being censured if the parent is unable to accept the referral.

7. The teacher may be unwilling or unable to take the time required for the additional task of working cooperatively with the clinic.

8. The teacher may be reluctant to talk to the parent about referral to the clinic because of a conflict in dual loyalties to the child and to the parent, with the teacher tending to take sides with the child. Along this line, the teacher may not be free to tell the parent how she really feels about the child. There is a sort of duplicity involved with negative feelings being stifled, and the teacher may avoid the discomfiture she would feel in this situation by not discussing referral with the parent. Of course, it is also true that there are some teachers who do not know how to prepare a parent for referral to the clinic.

9. It frequently happens that the teacher is uncertain as to when she should continue her attempts to handle the child herself and when she should refer the child to the clinic. Rather than reveal her uncertainty she continues to try to cope with the child in the classroom, sometimes against her own better judgment.

10. Finally, there is a still prevailing attitude among some school people that misbehavior such as truancy is always "bad" and that the proper referral is to the court. These people are unwilling to tolerate the child's absence even in the case of a school phobia. These same people are also unwilling to release the child for a clinic appointment which falls during school hours.

On the other side of the ledger, there are feelings and attitudes among the clinic staff which interfere with or obstruct good working relationships with the schools:

1. All too frequently the personnel of some clinics seems to minimize the work of teachers and their contribution to society.

2. The clinic staff thinks only in terms of handling cases without "outside" help or with a minimum of information from "outside" agencies.

3. They seem afraid to impart confidential information lest it cannot be entrusted to the teachers. Of course, the responsibility of the clinic to the individuals concerned has to be understood.

4. Sometimes in contacts with school personnel the clinic staff uses language which is too technical, perhaps to impress or perhaps to conceal, but in any event no real communication ensues. As a result of such contacts the teacher may complain that she wasn't told anything and that she learned nothing which would be of help to her. On the other hand, as a result of some contacts the teacher may complain that she was "talked down to."

5. Generally speaking, the clinic staff is quite ignorant of the work of the teacher. The clinic does not have the total view of the school function, the daily activities of the teacher in the classroom and the contribution of the teacher to the growth and development of a room full of normal children. The clinic sees only those cases which fail to fit into the daily classroom routine.

6. The staff tends to think of schools and teachers as they remember them from childhood, quite unaware of changes which have occurred in school procedures as a result of changes in the philosophy of education, in the curriculum and in the immediate approach to the child. At worst, they may still harbor negative feelings toward teachers as a result of their own unpleasant experiences.

7. The clinic staff may find it difficult to fit a school conference into the busy daily routine of appointments, dictation, closing summaries, letters to referring agencies, phone calls and staff conferences. This may lead them to regard the contact with the school as secondary or to feel that the school isn't interested.

8. Sometimes the clinic is afraid to get involved with the teacher for fear that the teacher will demand specific advice on specific techniques for handling the child, a demand which the clinic cannot confidently meet. The clinic staff is confident that it can be of assistance in helping the teacher explore the problem and work out with her courses of action which she may undertake, but it is not prepared to hand out ready-made advice on procedures which can be successfully followed by any teacher working with any particular type of problem.

Whatever the many factors from which stem the attitudes that prevent communication and cooperation between teacher and therapist, they are regrettable in that they detract from the effectiveness of both. They are doubly deplorable since undoubtedly the same mechanisms are at work on both sides and could be eliminated with a bit of mutual trust and confidence. If either side takes the lead in demonstrating trust and confidence as well as some understanding and appreciation of the problems of the other, cooperation invariably results from such action.

Assuming that both clinic staff and school personnel are aware of the sources of misunderstanding and have taken steps to obviate them and to establish good working relationships, the following suggested procedures would demonstrate real cooperation and could be followed:

1. With the permission of the parent, the therapist would send a letter to the teacher at the beginning of therapy notifying her of plans and requesting assistance from her.

2. Within several weeks the therapist would telephone the teacher and request a conference with her. They would agree on such points as the following: a mutually convenient time and place for the meeting, the participants, the necessary data to be available from the teacher and clinic, including descriptions of the child and his parents, the child's attitudes toward adults and peers, and an over-all evaluation of the strengths and weaknesses of the child as seen from both vantage points.

3. The conference itself would be conducted in an informal atmosphere with full awareness and recognition of the feelings and needs of all participants. Time for getting acquainted would be allowed and utilized. The conference would be planned and made a part of the schedule for the day and not squeezed into an already crowded lunch hour. The participants would be prepared to explain freely the clinic or school policies and procedures if any expressed or unexpressed need for it was apparent. The discussion of the particular child would include: definition of the problem or problems, the significance of the child's behavior, questions from all participants, recommendations and plans for action.

4. Continuation procedures would include a record of the conference filed by both parties and periodic follow-up contacts at critical points such as after a grading period, after clinic appointment cancellations, after significant comments from the child or the parent, after a parent-teacher conference and after termination at the clinic.

As a final word, if the school-clinic conference and all similar contacts can be conducted in an atmosphere of mutual confidence, respect and trust, the teacher will be assisted in her work, the therapist will find the teacher an indispensable ally, and both clinic and school will profit from the expanded effort. Together, they can better approach their common goal—the welfare of the child.

EDNA K. KEEFE, M.S.W.

Dynamic social work and the tranquilizing drugs

At this very hour there are at least 700,000 human beings crowded into the mental hospitals in this country and 300,000 are admitted each year at an annual cost of just over $1,000,000,000. Even then the care is woefully inadequate.[1] The development of drugs which not only sedate the patients but also facilitate other therapeutic approaches has been perhaps the most outstanding assault on this monstrous problem since Philippe Pinel and later Dorothea Lynde Dix marched on the bedlams of their eras.

Interest has been centered on two of these drugs—reserpine and chlorpromazine.[2] While there are others, these are in the widest use. Like other additions to the therapeutic inventory of neuropsychiatry, these drugs are of special interest to social workers. Our obligation to maintain a comprehensive acquaintance with the methods of related professional groups requires us to be conversant with these innovations in therapy. Both professional and lay publications have greeted this advance in chemotherapy as the harbinger that "ushers in a new era in the treatment of mental illness."[3] Not only the professional public but the general public is oriented to an optimistic and enthusiastic anticipation of the day when the disturbed ward with its restraints, pack-tables, tubs, isolation and bare living quarters will disappear, as patients, "thus reactivated, are capable of nat-

Miss Keefe was in the social service department of the VA Hospital at Murfreesboro, Tenn., at the time she read this paper before the local unit of the National Association of Social Workers. She is now case work supervisor at the VA Hospital at North Little Rock, Ark.

[1] Gilbert Cant, *New Medicines for the Mind; Their Meaning and Promise.* (Pamphlet No. 228.) New York, Public Affairs Committee, 1955.

[2] Dr. S. E. Abel, director of professional services, and Dr. C. C. Adams, chief of neuropsychiatric service, Veterans Administration Hospital, Murfreesboro, Tenn., have offered invaluable assistance in the preparation of the medical aspects of this paper. Smith, Kline and French Laboratories, Philadelphia, have generously furnished reprints of many articles concerning chlorpromazine.

[3] *The Treatment of Hospitalized Psychiatric Patients with Thorazine.* Philadelphia, Smith, Kline and French Laboratories, 1955, title page.

ural social behavior." [4] The moderately ill patients will then be treated in the community.

This changing focus of psychiatric care implies certain modifications of the role of the social worker, whether attached to the neuropsychiatric hospital, the out-patient clinic or the larger community. It has been said that about one-third of the patients who consult a physician do not have any definite bodily disease to account for their illness and approximately another third have symptoms that are in part dependent upon emotional factors.[5] These individuals can reasonably be assumed to be clients of various social agencies and in frequent contact with case workers and social group workers. Thus the advent of a drug to reduce tension and anxiety with a minimum of ill effects can be viewed as a boon not only to the psychiatrist, allergist, cardiologist, gynecologist, gastroenterologist and general practitioner but to the social worker as well.

While the drug therapy mentioned is in widespread use with large numbers of patients there has been little attempt to list the changes it brings in social work. This listing does not presume to be exhaustive but rather is thought of as a brief survey of some of the areas of increased emphasis in which we can heighten our contributions to the total therapeutic process.

Generally speaking, social workers are only superficially concerned with the mode of administration, the dosage and the pharmacology of chlorpromazine and reserpine. However, we need to be aware of the nature of this treatment and the reasoning involved in order to best serve the patient and his family. The dosage of reserpine may range from 0.1 mg to 130 mgs daily, while the range for chlorpromazine is roughly from 10 mgs to 2,000 mgs daily. In neither case is the amount related to diagnosis, body weight or many of the other factors which usually help to determine drug dosage.[6] Both drugs may be administered orally or intramuscularly, and chlorpromazine is available in suppositories. Each of these drugs seems to act on the lower centers in the thalamus and hypothalamus that serve as relay stations for nerve impulses between the environment and the brain's higher centers of consciousness.[7] As a result of the drug's "dampening" actions on such impulses the patient remains relaxed and quiet without descending into a stuporous and groggy state. The memory, judgment and intelligence remain essentially intact. Chlorpromazine "potentiates the effects of cerebral depressants, lowers the blood pressure, accelerates heart action and produces motor retardation, somnolence, and weakness.[8] The lethargy resulting from (it), in contrast to that produced by other sedatives, is characterized by clarity of consciousness and retained responsiveness. The drug, at any dosage, does not produce emotional disinhibition but selectively inhibits drive, which makes it unique among the more powerful sedatives." There is no evidence that reserpine in any way alters the schizophrenic process [9] nor any of the other major

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[4] *Chlorpromazine and Mental Health.* (Proceedings of a symposium held under the auspices of Smith, Kline and French Laboratories, June 6, 1955.) Philadelphia, Lea and Febiger, 1955, 84.

[5] Edward Weiss and O. Spurgeon English, *Psychosomatic Medicine.* Philadelphia, W. B. Saunders Co., 1949, 4.

[6] W. Theodore Lieberson, "The New 'Tranquilizing' Drugs: Neuropsychiatric Aspects," *American Journal of Nursing,"* 55(December 1955), 1465.

[7] Morton J. Rodman, "New Drugs of '55: Drugs in Neuropsychiatry," *R.N.,* 18(December 1955), 56–57.

[8] Harry Beckman (ed.), *Year Book of Drug Therapy.* Chicago, Year Book Publishers, 1955, 469.

[9] *Ibid.,* 453.

psychoses, but rather it serves principally to make the patient more tractable, counteracting confusion [10] and facilitating psychotherapy. "Because the patient is no longer preoccupied with discussing the symptoms which come from his disturbed autonomical nervous system, he is more willing to discuss dynamically important material. In addition, he is less inhibited and will bring out more dynamic material which . . . makes psychotherapy far more effective." [11]

The drugs were originally introduced for other purposes and their tranquilizing effects were soon noted. In addition to its uses with neuropsychiatric patients, chlorpromazine is effective in the control of nausea and vomiting, alcoholism, intractable pain, in the management of cancer patients, in obstetrics, surgery, pediatrics, asthma, neurodematitis, and in relieving the withdrawal symptoms of narcotic and barbiturate addiction, as well as in other conditions too numerous to mention.[12] Other studies show that these drugs are also effective in work with maladjusted children as well as adults.

The advent of drug therapy does not mean an end to the era of psychotherapy and, as students sing, "the glory of the theory of Freud." In his essay "On Narcissism," written in 1914, Freud suggests that ". . . we must recollect that all our provisional ideas in psychology will some day be based on an organic substructure. This makes it possible that special substances and special chemical processes control the operation of sexuality and provide for the continuation of the individual life in the species. We take this probability into account when we substitute special forces in the mind for special chemical substances." [13]

Hospital administrators feel that the emphasis on drug therapy increases the demand for personnel as there is a shift from custodial to therapeutic care. The demands for competent services in the community are also increased and yet the number of trained personnel is completely out of step with the need. "There is an acute shortage of persons trained in every one of the helping disciplines." [14]

The increased use of the drugs and the ensuing increased demand for case work services does not change the basic functions of the profession but rather highlights their importance. In the area of therapeutic case work the lessening of confusion and the enabling of the patient to discuss the nature of his conflicts make an entirely new group of individuals available for case work services.

At the Veterans Administration Hospital in Murfreesboro, Tenn., these drugs have been in use since June 1954. The first patient, a manic, was well aware of the nature of his drug therapy and derived considerable satisfaction from engaging staff members for long periods, describing the changes he experienced and making a comparison from his voluminous notes with the previous forms of therapy which he had received. This pointed out the first implication for social work service: there was an increased desire to talk with personnel. This has been borne out in our subsequent experience.

As larger groups of patients have been treated the number who were too confused

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[10] *Thorazine in the Management of Senile Patients.* (Psychiatric Briefs No. 3.) Philadelphia, Smith, Kline and French Laboratories, 1955.

[11] *Chlorpromazine and Mental Health,* 129.

[12] *Thorazine Reference Manual.* Philadelphia, Smith, Kline and French Laboratories, 1955.

[13] Sigmund Freud, *Collected Papers.* Vol. 4. London, Hogarth Press, 1948, 36.

[14] Kenneth D. Johnson, "The Contribution of Orthopsychiatry to Social Work," *American Journal of Orthopsychiatry,* 25(July 1955), 471.

to make use of case work services has diminished and there is an ever-increasing stream of referrals not only from the ward personnel but from patients themselves. Our previous contacts with one patient had been limited to his requests for help in securing legal assistance to "break the commitment," but are now the result of his fearful suggestion that his family may not want him when he is ready for a trial visit.

An awareness of the patient's probable progress under drug therapy will make it possible for us to intervene therapeutically at the proper time to build a productive relationship. This not only frees the psychiatrist to work with the more seriously disturbed patients but also offers the social workers an opportunity to expand their role as auxiliary therapists. This does not imply the use of the social worker as a psychotherapist [15] but rather increases the emphasis on effecting the maximum utilization of our clearly accepted means of treatment. In the light of drug therapy our roles in "environmental modification," "psychological support," "clarification" and "insight development" [16] shift as these case work techniques are applied to our differentiated functions. It is felt that this is equally true whether the service is hospital admission, emotional and personality adjustment, trial visit planning and supervision or outpatient care.

The number of patients who come to the hospital having received "psychiatric first aid" will increase as the general practitioner becomes more secure in the use of chlorpromazine and reserpine. The masking of the symptoms can be dangerous for all concerned. One patient initially appeared to be in good remission but soon became assaultive, hyperactive and destructive. Adequate history revealed that he had been receiving substantial doses of chlorpromazine and during the early days of his hospitalization at Murfreesboro was not considered in need of the drug, owing to his clinical picture. Consideration of such problems makes the necessity for an accurate history obvious if there is to be continuity of therapy.

Many families are familiar with the publicity given the ataraxic drugs and raise questions concerning their use. One mother arrived for an interview armed with an article from a current lay publication and demanded the reasons why her son was not being given that drug. The simple explanation that the doctor considered another drug more desirable would do little to strengthen the relationship and make it possible to discuss her hostility, rejection and basic guilt. She refused the initial offer to talk with the doctor. After considerable discussion of the material in the article, coupled with information concerning the drug her son was receiving and her observation of his symptoms, she was able to say that the drug prescribed was satisfactory.

Not all the publicity accorded chlorpromazine and reserpine is confined to the therapeutic aspects of the medication but encompasses the undesirable side-effects as well. Both the patients and their families have fears that will be brought to the case work interview. Frightening symptoms such as jaundice, Parkinsonism, skin rashes, *etc.*, tend to increase the patient's physical dependency and alter his emotional needs.

A particularly fearful patient spent many hours of distress before coming to the point at which he could complain to his social worker that he was becoming weak and had difficulty keeping awake. Repeated as-

[15] Jules V. Coleman, "Distinguishing between Psychotherapy and Casework," *Journal of Social Casework*, 30(June 1949), 244–51.

[16] Florence Hollis, "The Technique of Casework," *Journal of Social Casework*, 30(June 1949), 235–44.

surance and interpretation was necessary before he could accept this as a natural result of medication. Soon after a large group of patients on a chronic disturbed ward were placed on chlorpromazine, one died suddenly. The others became fearful and anxious, increasing in emotional dependency on the staff. The effect of these drugs has been demonstrated to vary to an amazing extent with the patient's mood and with many environmental factors.[17] At the same time Lemere reports 11% of the placebo patients used as a control in his study told of specific side-effects which they had been warned against.[18] Aside from the genuine fears at a reality level, families may tend to ascribe many of the patient's symptoms to the drugs out of their own needs just as many seek to absolve their guilt by assuring us "he was all right when they took him into the Army." In our hospital this problem requires special attention since families may visit any day and are encouraged to come frequently.

The course of behavior for a patient under reserpine therapy, as described by Barsa and Kline, follows a pattern of a sedative period, a turbulent period and finally a period of integrative behavior.[19] If this is not understood by personnel and interpreted to the family, the period of increased turbulence may be quite anxiety-provoking. It is in this stage that the patient may become more delusional and the hallucinations often become more pronounced. There are outbursts of overactivity accompanied by aitercations with little or no provocation. During this same period there may be emotionally intense and vivid dreams that are quite upsetting to the patient.[20]

One patient whose entire history was characterized by his inability to verbalize his hostility had been seen regularly by the social worker for many months. Under drug therapy he suddenly became verbally abusive, profane and threatening. The social worker was able to weather his emotional storm without becoming alarmed and soon moved into increasingly productive case work areas.

The attitudes of personnel are only a part of the therapeutic climate at such a time. The family must be oriented to expect such actions as a part of the patient's long and tenuous sojourn to readjustment. Family attitudes must be utterly free of judgmental or retaliative reactions which might imply punishment or threats of such or disapproval of the treatment, for it is when the patient sees that his behavior is tolerated that he becomes aware that he is wanted and accepted. The role of the social worker in the amendment of family attitudes is so well accepted as to require no further comment; this function, however, like others is highlighted by the advent of the tranquilizing drugs.

As larger groups of patients increase their contact with reality it is reasonable that larger emphasis will be placed on group therapy. The proceedings of a symposium on chlorpromazine and mental health held under the auspices of Smith, Kline & French Laboratories [21] point out that even the wide use of group therapy alone will not solve the problem since there will still be an acute shortage of psychiatrists. Dr. Denber [22]

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[17] Rodman, *loc. cit.*

[18] Frederick Lemere, "Combined Chlorpromazine-Reserpine Therapy of Psychiatric Disorders," *Archives of Neurology and Psychiatry*, 74(July 1955), 2.

[19] J. A. Barsa and N. S. Kline, "Reserpine in the Treatment of Psychotics with Convulsive Disorders," *Archives of Neurology and Psychiatry*, 74(July 1955), 31–35.

[20] Beckman, *op. cit.*, 249.

[21] *Chlorpromazine and Mental Health*, 142–53.

[22] *Ibid.*, 150.

suggests the inclusion of the principles of group psychotherapy in the curriculum of psychiatric social workers. While this would seem reasonable, it does little to help those of our number who have long since completed their formal training. The social group worker would become increasingly important to the hospital setting in creating opportunities for progressive steps in participation and development of relationships, which make the group situation an important therapeutic tool.[23]

Many chronic patients for whom there previously had been little hope are now becoming candidates for trial visit. The implications of this shift in prognosis are apparent in the story of one 53-year old patient whose illness dated back to 1936. He had been hospitalized continuously since 1942, without privileges, trial visit or leave of absence. His hospital course was characterized by extreme hyperactivity, frequent altercations and destructiveness, making him a difficult problem in ward management and requiring two packs almost daily until he was begun on chlorpromazine. All observers considered indefinite hospitalization necessary. He soon became extremely tactful, rational and cooperative, and was given privileges and an opportunity to work in the leather shop. He has now been on trial visit since Thanksgiving 1955 and is employed full-time at a baking company.

As larger groups of patients recover from the acute phases of their psychosis, the problems of trial visit planning and supervision will be brought into sharper focus. Not only will the social worker be asked to plan for the individual who will return to approximately the same family unit that he came from, but there will also be chronic patients whose family units have undergone drastic revisions. The family that is asked to effect the new adjustments required in planning for a person who has been mentally ill may have had a very long period in which to become accustomed to his absence or it may be a family composed of individuals who have little or no memory of the patient in his pre-psychotic state. The simple act of recovering from the acute stages of his illness and improving socially in terms of his hospital conduct is only the first step in a successful readjustment to extramural life. The social worker is in a unique position to complement and supplement the formulation of plans that will be acceptable to the patient, his family, the community and the hospital. Many of these patients will not be able to return to the community from which they came and will require nursing homes or foster home care, increasing the demands in these areas. Thus we see how the advent of chlorpromazine and reserpine adds increasing importance to our current functions.

Patients return to the hospital from trial visit for essentially the same reasons they were first institutionalized. Either they are unable to accept their environment or it is unable to accept them with their limitations and problems. We are all familiar with the traumatic effects of unsuccessful trial visits and seek to avoid them by careful planning and accurate appraisal of the degree of readiness of the home. Our efforts have always been limited by such problems as geography, limited contacts with the family, prejudice and the other myriads of problems which militate against our efforts to help effect changes in the environment.

These failures are generally viewed as the "fault" of the patient. The aim of therapy is to help him to "adjust" and we are hampered in our efforts to help the family

[23] C. G. Gifford, E. E. Landis and S. Spafford Ackerly, "Enhancing Group Living in the Hospital Setting," *American Journal of Orthopsychiatry*, 23 (January 1953), 142–57.

adjust. Dr. Nathan Kline has suggested that "the patient is usually viewed with suspicion upon his return home. If he expresses any opinion or behaves in any way contrary to the standards set up by his wife, mother or children (no matter how peculiar these standards may be), this is immediately attributed to the fact that he is still slightly 'teched'." [24] Dr. Kline suggests two procedures for helping increase trial visit adjustment: first, to continue the patient on medication so he can better tolerate the pressures of adjustment and, second, to place the family on chlorpromazine so that they are better able to tolerate him! In fact, Dr. Kline has tried this technique with gratifying results. Unfortunately, we as social workers must act in the presence of the first therapy and as yet in the absence of the second. Here we substitute case work for drugs in the effort to mobilize both individual and community resources to assist the patient in his rehabilitation.

Many of these patients will require a great deal of help during the time that they are making the initial adjustment to trial visits. Our chronic patient last mentioned above got along poorly during the first weeks of his effort to readjust to community living. With the support of his family and the help of out-patient care, reinforced by drug therapy, the conflicts were soon resolved. Then came the problem of employment for a person who had not been in the labor force for a number of years. All of these problems tend to emphasize the need for increasing close supervision of trial visits and for frequent case work contacts.

The experience with chlorpromazine and reserpine is yet too limited to tell us how long patients can or will be maintained on medication, but it has been suggested that the mentally ill may use these drugs in much the same fashion that the diabetic uses his insulin. Recently a trial visit report concerning one of our patients asked, "How long can he be maintained on chlorpromazine"? This patient has been out of the hospital eight months after a history of many years of assaultive behavior, paranoid ideas and severe physical distress resulting from the notion that he was pregnant. Now he raises chickens, plans to plant cotton, and helps neighbors mend their fences, while chlorpromazine helps him to mend his inner fences.

In general, the advent of drugs which produce ataraxia or "freedom from trouble in the mind" increases the demands on the social worker. Contacts must be initiated as early as possible in order to make the optimum use of hospital social work service and to provide for an early referral to the social worker in the community.

We must learn all we can of this new therapy, sharpen our case work skills, learn to function at a more complex level of interpersonal therapy and reevaluate our specific services. Trial visit planning must move out of the realm of "will the family take him?" and into the areas of "how will the family and the community help him?" Trial visit supervision must offer real case work help to the patient and his family and at the same time activate the community in his behalf. Checking up on the patient is no longer sufficient.

The challenge is clear. All this is only preface to the monumental task of the new era of psychiatric care, and ours is an exciting role.

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[24] *Chlorpromazine and Mental Health,* 157–58.

ESTHER L. MIDDLEWOOD

Visual aids for mental health

If one initially doubted the value of visual aids to the learning process, such doubt can no longer be justified in light of the tremendous development of the documentary film business and the impact of television. Since time began man has illustrated his writings; in fact, illustration probably came first. Innumerable studies have been made in the field of education to determine the value to the learning process of the combination of aural and visual impressions. The question as to the value of films in teaching arises only when it is applied to mental health. But when the question is raised, it is not teaching by film that is challenged but mental health education itself. Those who object to mental health education raise questions as to whether personality can be changed through education, whether learning about mental health produces anxiety, or whether we know enough about the positive aspects of mental health to provide a body of teachable knowledge.

Such questions are certainly valid, but most of these questions are raised by the clinicians, whereas many of us who are involved daily in working with groups of people have come to feel that their objections are based on false premises.

Mental health education generally is planned for those who are not critically ill. Granting that the ill cannot be made well, there is still a place for mental health education for the masses of people who are concerned about all knowledge, especially as that knowledge touches the world which is uniquely their own. Undoubtedly there

Miss Middlewood, who is chief of the education section in the Michigan Department of Mental Health and a member of the Mental Health Film Board, delivered this paper March 8, 1957 in Chicago before the audio-visual section of the American Orthopsychiatric Association.

will be those who become anxious, but this is not always disastrous. Were we to relieve individuals of all anxiety, there would be some question as to how much, if any, learning would occur. It is a sad indictment of our professional group if we admit that there is no teachable body of knowledge in the field of mental health. Even the most querulous must accept facts such as that there are individual differences in children, that the mentally ill are not set upon by witches, that family patterns are changing. Human beings are in quest of knowledge and they have a right to have access to whatever knowledge is available, incomplete though it may be. Even the knowledge of its incompleteness and fallibility should be allowed them.

For the purpose of this paper, however, we accept the "fact" of mental health education and will explore briefly the possibility of the use of films in that process.

Critics frequently look at a mental health film and decry its use because they can point to a flaw from their point of view. Such flaws may well be a strength of the film and serve as a point of departure for the discussion which follows the film showing. "Angry Boy" has such a flaw. From the point of view of the educator, the manner in which the child's stealing episode was handled by the school principal was wrong. At first, many educators resisted the use of the film on this basis. Gradually, however, they came to see that the feeling aroused was good and spurred them into challenging thought. With ample opportunity to discuss the point at issue, many came to see that the practice presented in the film was all too frequently used, and they were stimulated to discuss the pros and cons of such handling and eventually to design better practice. For those who look for a design of perfection, there is none. All that is essential is an honest portrayal of a given situation—not good, not bad—it just is! Such a film directs the minds of the people to concerted thinking about a given concern and allows for more purposeful discussion.

Some people look to the mental health film to teach them how to do a specific thing. Because documentary films were originally designed to illustrate facts, we became accustomed to an illustrative type of film. In the field of health, the sanitarian knew how a septic tank should be built. With the aid of a draftsman, he could design and photograph such a tank to illustrate the construction process. The processes of caring for a bed patient, of selecting foods, of caring for a dairy herd could be illustrated as well. In these instances there is a "best" way, and there is an innate element of demonstrativeness about the process concerned. In the realm of human behavior, such universality of process is not true. There are many ways of reacting to a given situation, an infinite variety of patterns an individual may pursue in his search for a solution to a given problem, and a procession of concepts of happiness as endless as the procession of humanity itself. There is no mental health film comparable to a film on the construction of a septic tank. For the user of films who looks for such easy answers to mental health education, there is little other than disappointment. The producer of films who attempts to design films of this nature is not well versed in the principles of personality development. Some such films have been made, but the discerning user immediately senses their superficiality. Tragically many undiscerning persons are using mental health films.

In apparent contradiction to the foregoing statement, there are some films which are purely descriptive, but even these films do not "point the way." They simply de-

scribe. "It's A Big Problem," which describes the problem of mental illness in Michigan and our attempt to meet the problem, is such a film. No attempt has been made to establish an example or pattern. It is essentially descriptive. In another area of concern, human behavior, "Age of Turmoil" describes pictorially the behavior of six teen-agers within a limited space of time—a Friday afternoon and evening. No attempt is made to indicate that all teen-agers act as these six nor that these six would act that way at all times. The value of the film lies in the visual stimulation to the minds of the viewers, in its effort to add variety and scope to their thinking about the teen-agers they know. It causes a friendly, receptive attitude toward adolescents in general. No one is particularly involved emotionally with the concerns of any one of them, yet the film leads an audience to a better understanding of teen-agers and their relationship to the adults in a given group.

Another illustration of the documentary film which is purely descriptive is "Stress." Nothing is said in this film that could not be said on the printed page, but to have the interesting personality of the doctor presenting his own concept of stress, with some illustrative sketches, adds tremendously to interest. Interest, we know, is conducive to learning. Whether or not the concept presented is accepted by all is not a fact in question. With the variety of concepts in any area of mental health being presented, we would freeze into immobility if we awaited consensus—a time which hopefully will never arrive.

Many of those who would grant the use of the aforementioned films deny the use of yet another type of film—that which involves human emotions. Instead of an illustrated lecture, the film becomes a lesson in feeling. As contrast, we can compare "City of the Sick" and "Man to Man." The former sympathetically describes life in a mental hospital so that one arrives intellectually at a better understanding of what takes place there. Hopefully there are concomitant emotional gains in increased acceptance of the mentally ill. In "Man to Man" you suffer with Mr. Rusk, the patient. You feel the infinite appeal of his mute need and await his next move on the checkerboard. You feel with the attendant his disappointment when the patient's progress is inadvertently deterred. The processes of the hospital become incidental but somehow are absorbed into one's consciousness. Once having lived with Mr. Rusk in the depth of his sorrow, you find yourselves a bit closer to a sympathetic understanding of the deeply buried misery behind the apparently meaningless and often bizarre behavior of the mentally ill. Such an emotional involvement is the design of many mental health films and is the aspect of such films against which much criticism is directed.

It is the feeling of some in the psychiatric field that films which involve the feelings of people are too charged to be available for general usage. This may be true with a select few, for we must remember that some films, such as "Feelings of Depression," were originally conceived as therapeutic films; there is cause for concern when they are used by the psychiatrically untrained. However, this is only one level of emotional involvement. Most films are not so designed. Most films are story films which tell a story of people living with people. Emotions are involved just as they would be involved in any living episode. But we forget that people have spent their entire lives building up defenses to protect themselves in vulnerable spots, and such films do not disturb them. We watch television plays and movies which

are powerfully charged—not all in ways that threaten the defenses of any one individual, but any one individual must have his defenses shaken many times if he watches plays and movies often. The psychiatrist is not at all averse to giving a lecture from which there is no escape psychologically. The words of authority from one who is learned in his profession are much more to be feared than a movie conceived in the realm of make-believe. The film viewer who must have an escape can find an escape from a movie; the American public has learned many escapes. For those who have no need to escape there is possible a depth of learning which could never be realized from the spoken or written word alone.

Most films are neither descriptive nor deeply therapeutic. Most of them use emotion in such a way that a viewer can become involved sufficiently to give real meaning to his viewing experience. This is how growth occurs.

The depth to which interpretation goes depends almost entirely upon the audience, the leader and their interaction. A film such as "Fears of Children" can become a springboard into an exploration of neurotic anxiety, or it lends itself well to stimulate a discussion on such topics as the differences in attitudes toward discipline between fathers and mothers and how to handle these differences, or to an exploration of what overprotection may mean to a mother and a child. Audiences and leaders who do not know about neurotic anxiety somehow are not in the least worried about the fact that it doesn't come up for discussion. Psychiatrically oriented people are handicapped in viewing a film as the usual audience views it. They look for the hidden and obscure. Their knowledge makes it so. Others are not possessed of this same knowledge, yet they can learn many lessons about human behavior within the framework of their knowledge and background. Those who are pricked a bit by anxiety into greater insight take what they can, discard or disguise the intolerable, and await the next impact for growth.

Granted that we accept the use of films in mental health education, there are a few guideposts that have emerged out of our cumulative experience. First, most films are best received if the audience is given a little preparation. Some films, for instance, have elements of strangeness to a given audience. So that they don't become immersed in the strangness, they need to be forewarned. "Roots of Happiness" can be so much more meaningful if it is pointed out that even though the film depicts another culture there are great common elements of the human beings involved. Unless one does, it may become a "travel film" and the audience may feel, "It couldn't happen here." The language of the South in "Hard Brought Up" is so pronounced to a northern audience that it can well become a game to listen for idiosyncrasies of speech rather than to the story of two unhappy little boys. The Canadian aspects of "Family Circles," the British terminology of "Your Children and You," or the way of life of the Negro in "Palmour Street" may stand in the way of real learning. Such preoccupation with elements strange to the life of the audience involved can be relieved with appropriate introduction.

An introduction can partially direct the thinking of the audience and adds to the versatility of any film. For instance, one might want to use "Palmour Street" or "Fears of Children" to focus attention on fathers and the role they play in family life. A few introductory remarks can help the audience to attend to factors which might otherwise have little significance.

In dealing with mental health films, as in dealing with all mental health education, semantics become extremely important. Every profession builds up its own professional shorthand; psychiatry and its allied professions are no exception. We have endowed certain words with a whole aura of meaning completely unknown to the usual person. We have become comfortable with words charged with emotion for many. Unless we are able to eliminate our jargon shorthand when doing educational work, it is usually best undone. Dynamic behavior can be understood in simple language, but many of us find it difficult to make this translation.

When one wishes to utilize the emotions of people engendered by the emotions in a film, the mechanical projection of the film becomes exceedingly important. To have the flow of feeling disrupted by faulty sound, ideas broken by a broken film, or interest aborted by faulty light allows the members of the audience to release their feelings into many channels—irritability, anger, humor or sympathy for the projectionist. Any of these "uncharges" the individual, and at the end of the picture—it's over. So what? Such an attitude is not very conducive to the discussion which follows, during which the "digestive" process occurs and learning takes place.

With all of their shortcomings and with all of the admonitions one hears, the films available for mental health education are becoming better and more varied. As in any field of growing popularity there are those who are looking only for the easy dollar or the easy program. Together they are a formidable team. But as long as sincere producers produce good films and mental health educators constantly strive toward honest selection, we can hope for a gradual development of a good mental health film library. With good films available, the rest depends upon a consistent effort to train people in the appropriate use of those films. With good films the task of mental health education is made easier.

BENJAMIN MALZBERG, PH.D.

Cohort studies of mental disease in New York State: 1943 to 1949

PART IX. GENERAL SUMMARY

Cohort studies are an attempt to arrive at the natural duration of a disease—that is, the interval between the onset of a disease and its termination. In the case of mental disease this ideal cannot be reached because the date of onset cannot be determined with sufficient accuracy in many cases. In its place we therefore substitute the date of first admission to a mental hospital. The decision as to the time of termination of a mental disease is also beclouded. Patients are discharged presumably after recovery or after some other degree of improvement, or by death. The end-point would be relatively simple to determine if there were good agreement as to the patient's condition leading to discharge. Such judgments differ, however, because of the subjective element. It is therefore difficult to ascertain the correct duration of a mental disorder even when one substitutes administrative guides for natural limits. Cohort studies are in effect a mixture of administrative and medical procedures. From an administrative standpoint it is sufficient to measure the duration from the date of first admission to a mental hospital to the date of leaving, whether by placement in convalescent care, by discharge without such placement or by death. From the "natural history" point of view, however, the date of placement in convalescent care is not the end of treatment but a continuation of treatment under new conditions. When convalescent care is judiciously administered, and not in a routine manner, such discharges provide a better approximation to the termination of treatment. For the purposes of these studies, therefore, the duration of treatment (*i.e.*, hospitalization) includes time in convalescent care.

The cohorts analyzed in these studies represent first admissions to the New York civil

state hospitals during five successive fiscal years beginning with the year ended March 31, 1944. The closing period of observation occurred in each case during the year ended March 31, 1949. A maximum uniform period of observation of five years was therefore available for the first cohort. The period was reduced by a year for each succeeding cohort. The period for the fifth cohort was therefore only one year.

The following analyses show discharges and deaths in relation to periods of hospitalization after first admission. All the five cohorts were under observation during the first year after admission; hence percentages and rates for this period are an average for all the cohorts. Only the first four cohorts were under observation for two years and they therefore furnish the basic exposures for this period. Finally, only one cohort, that of 1943–44, was under observation for the full five years and fur-

TABLE I

Percent of first admissions to New York civil state hospitals discharged during specified periods after admission, classified according to mental disorders

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months	9.5	2.7	21.5	3.2	1.5	6.2	20.4	7.4
Second three months	2.5	1.5	3.3	0.6	0.3	2.1	4.1	4.3
Third three months	1.3	0.6	1.4	0.5	0.3	0.8	1.6	2.3
Fourth three months	1.1	0.5	1.0	0.4	0.2	0.5	1.1	1.7
First year	14.4	5.3	27.2	4.7	2.3	9.6	27.2	15.7
Second year	21.5	19.9	30.4	8.8	2.8	49.5	48.8	36.8
Third year	3.8	3.4	5.4	1.2	0.4	7.0	4.6	7.9
Fourth year	1.6	1.8	1.8	0.8	0.4	1.6	1.4	3.2
Fifth year	0.7	0.8	0.8	0.1	–	0.5	0.6	1.9
				FEMALES				
First three months	6.7	2.6	13.1	2.8	1.6	7.1	14.9	5.6
Second three months	2.0	2.0	3.1	0.6	0.2	1.4	3.8	3.4
Third three months	1.0	0.3	1.1	0.3	0.1	1.3	1.3	1.7
Fourth three months	0.8	0.8	1.0	0.5	0.3	1.0	1.3	1.1
First year	10.5	5.7	18.3	4.2	2.2	10.8	21.3	11.8
Second year	26.5	25.8	42.8	11.2	3.0	46.9	57.0	39.7
Third year	4.2	4.1	6.3	1.3	0.6	6.8	6.1	7.2
Fourth year	1.6	1.1	1.8	0.4	0.2	3.7	1.9	2.6
Fifth year	0.7	0.5	0.8	0.1	0.1	1.4	0.4	1.4

nished the necessary exposures for this period.

Table I summarizes the discharges by percent during specified periods of hospitalization. Of the males 14.4% were discharged during the first year and 21.5% were discharged during the second year. The higher percentage during the second year resulted from the culmination of periods of convalescent care, the great majority of which were made during the first year of hospitalization. Relatively few discharges occurred after the second year. There was great variation in these percentages among the principal groups of mental disorders. As might have been expected, discharges were relatively few among psychoses with cerebral arteriosclerosis and senile psychoses. They were most frequent, relatively, among manic-depressives, of whom 90% were discharged within two years. The percentages were also high for the alcoholic and involutional groups and relatively high for dementia praecox.

The general picture was the same for females, of whom 10.5% were discharged during the first year and 26.5% were discharged during the second year, a total of 37.0%. Only an additional 6.5% were discharged after the second year. The percentage was highest among manic-depressives, of whom 78.3% were discharged during the first two years. During the same period 61.1% of the female alcoholics were discharged. The percentage for the involutional group was 57.7. Of female first admissions with dementia praecox 51.5% were discharged during the first two years. As with males, discharges of females were few among first admissions with psychoses with cerebral arteriosclerosis and especially low for the senile group.

The percentages are shown cumulatively in Table II. Of all the male first admissions an average of 42.0% were discharged within five years after admission. This was almost doubled by the group of manic-depressives. The final cumulative percentages, all well above the average for all first admissions, were almost on a par for the following groups: alcoholic psychoses, 65.6; involutional psychoses, 68.2; dementia praecox, 65.5. Of the arteriosclerotic group only 15.6% were discharged. The total for the senile group was only 5.9%. Although low in comparison with the functional groups the total percentage of discharge for general paretics was surprisingly high.

The cumulative percentages for females were very similar to those for males. The average for the five years for all first admissions was 43.5%. There was a minimum of 6.1% among the seniles and a maximum of 86.7 for the manic-depressives. The total cumulative percentages were 70 for the alcoholics, 69.6 for the involutional group and 62.7 for the dementia praecox patients. As with males, the discharges among female general paretics may be considered relatively high.

Table III shows average rates of discharge per 1,000 annual exposures. Among all male first admissions the rate was highest during the first three months and decreased during the remainder of the first year. Because of the expiration of convalescent care the rate rose during the second year but decreased steadily thereafter to a minimum during the fifth year. The rates were highest for manic-depressives. The rate for this group was 847.0 for the first three months, averaged 281.4 for the first year, rose to 750.0 during the second year and dropped to a minimum of 83.3 during the fifth year. Rates were also high among the alcoholic group. The rate was very high during the first three months but averaged 281.7 for the first year. It rose to a maximum of 471.8 during the second year. Rates for dementia praecox were above the average for all

males and reached a maximum of 454.2 during the second year. Rates were low for the groups of advanced age, especially for the seniles.

The trend was similar for females. Rates were high during the first three months but lower during the remainder of the first year. Because of the expiration of convalescent care they rose to a maximum during the second year, then declined to a minimum during the fifth year. Rates were highest for manic-depressives and alcoholics, lowest for the senile group.

An earlier study of a cohort of first admissions to the New York civil state hospitals during 1909–10 permits of comparison with the preceding data on discharges. Of all first admissions during the period of 1944–48, 43% were discharged within five years. When adjusted for readmissions this figure did not differ significantly from the cor-

TABLE II

Cumulative percent of discharges among first admissions to New York civil state hospitals during specified periods after admission, classified according to mental disorders

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months	9.5	2.7	21.5	3.2	1.5	6.2	20.4	7.4
Second three months	12.0	4.2	24.8	3.8	1.8	8.3	24.5	11.7
Third three months	13.3	4.8	26.2	4.3	2.1	9.1	26.1	14.0
Fourth three months	14.4	5.3	27.2	4.7	2.3	9.6	27.2	15.7
First year	14.4	5.3	27.2	4.7	2.3	9.6	27.2	15.7
Second year	35.9	25.2	57.6	13.5	5.1	59.1	76.0	52.5
Third year	39.7	28.6	63.0	14.7	5.5	66.1	80.6	60.4
Fourth year	41.3	30.4	64.8	15.5	5.9	67.7	82.0	63.6
Fifth year	42.0	31.2	65.6	15.6	5.9	68.2	82.6	65.5
				FEMALES				
First three months	6.7	2.6	13.1	2.8	1.6	7.1	14.9	5.6
Second three months	8.7	4.6	16.2	3.4	1.8	8.5	18.7	9.0
Third three months	9.7	4.9	17.3	3.7	1.9	9.8	20.0	10.7
Fourth three months	10.5	5.7	18.3	4.2	2.2	10.8	21.3	11.8
First year	10.5	5.7	18.3	4.2	2.2	10.8	21.3	11.8
Second year	37.0	31.5	61.1	15.4	5.2	57.7	78.3	51.5
Third year	41.2	35.6	67.4	16.7	5.8	64.5	84.4	58.7
Fourth year	42.8	36.7	69.2	17.1	6.0	68.2	86.3	61.3
Fifth year	43.5	37.2	70.0	17.2	6.1	69.6	86.7	62.7

TABLE III

*Rates of discharge * among first admissions to New York civil state hospitals during specified periods after admission, classified according to mental disorders*

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arterio-sclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months †	453.4	130.5	889.2	184.1	95.2	258.9	847.0	301.5
Second three months †	146.3	81.4	176.1	39.6	25.9	95.9	224.4	171.2
Third three months †	84.6	37.2	83.0	35.7	27.9	40.0	92.8	105.8
Fourth three months †	65.8	33.4	61.9	33.4	23.8	24.5	63.6	80.3
First year	166.5	63.7	281.7	62.9	33.5	100.6	281.4	158.6
Second year	395.4	352.6	471.8	231.4	94.5	623.9	750.0	454.2
Third year	134.2	111.9	167.1	57.5	25.4	242.4	327.9	176.9
Fourth year	74.1	78.2	78.7	54.8	33.6	77.4	166.7	87.6
Fifth year	36.4	45.4	39.2	5.4	–	35.7	83.3	57.2
				FEMALES				
First three months †	309.2	118.3	545.3	152.0	93.0	297.0	612.5	228.1
Second three months †	108.3	104.7	154.0	43.3	12.1	66.7	187.6	147.7
Third three months †	57.4	21.0	55.9	25.9	7.6	60.4	69.1	75.1
Fourth three months †	49.9	44.1	50.8	43.6	26.6	47.3	70.7	49.7
First year	119.8	66.0	189.4	56.1	30.4	112.1	218.7	119.3
Second year	429.1	388.9	589.3	268.0	78.8	585.3	767.6	467.5
Third year	136.0	115.4	222.1	57.0	24.4	211.0	390.0	158.9
Fourth year	66.7	41.7	107.5	25.7	9.4	143.1	250.0	68.5
Fifth year	32.9	21.1	62.5	9.2	5.8	61.4	108.1	37.4

* Per 1,000 annual exposures.
† On an annual basis

responding percentage for the cohort of 1909–10. This must be attributed to the great increase of first admissions with psychoses with cerebral arteriosclerosis and senile psychoses, both of which have low rates of discharge. On the other hand, there has been great improvement among other groups of first admissions. Of general paretics 17% were discharged within five years during the early epoch. During 1944–49 the percentage was doubled, a consequence of the new methods of therapy. The introduction of the shock therapies also brought about higher rates of discharge. Thus 57% of the early cohort of manic-depressive first admissions were discharged within five years, compared with 75% of the current cohorts. A similar increase occurred

in connection with dementia praecox, the percentages of discharge within five years being 30 for the early cohort and 60 for the current cohorts.

Table IV shows the condition of the patients who were discharged within two years after hospitalization. This period was selected because almost 90% of the discharges among the first four cohorts occurred within this period. Of all the males 12.4% were recovered. This varied from minima of 0.6% for the seniles and 2.9% for the arteriosclerotics to a maximum of 44.1% for the manic-depressives and 40.4% for the alcoholics. The involutional group had a relatively high percentage of recovery, 31.3. Those showing any degree of improvement, including recovery, totaled 31.2%. These percentages varied from a minimum of 4.1 for the senile group and 12.5 for the arteriosclerotics to a maximum of 75.0 for the manic-depressive group, 57.3 for the involutional and 56.9 for the alcoholic groups. It may also be noted that 11.9% of the first admissions with dementia praecox were discharged as recovered and that 46.8% showed some degree of improvement including recovery.

In the case of the females 14.6% were discharged as recovered. This varied from

TABLE IV

Discharges among first admissions to New York civil state hospitals, in percent, within two years after admission, classified according to mental disorders and condition at discharge

CONDITION AT DISCHARGE	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
Recovered	12.4	5.3	40.4	2.9	0.6	31.3	44.1	11.9
Much improved	11.0	13.1	10.3	5.2	1.3	18.0	21.7	20.4
Improved	7.8	5.1	6.2	4.4	2.2	8.0	9.2	14.5
Unimproved	2.8	1.7	1.1	1.3	1.0	1.5	1.2	5.9
Without psychosis	1.7	–	–	–	–	–	–	–
Total	35.8	25.2	58.1	13.7	5.1	58.8	76.1	52.7
				FEMALES				
Recovered	14.6	6.1	39.3	3.7	0.6	28.8	48.4	16.3
Much improved	12.3	16.0	14.1	5.6	1.2	17.3	18.2	20.9
Improved	7.4	7.8	6.0	4.9	2.3	9.2	8.2	10.8
Unimproved	2.3	1.7	2.1	1.4	1.1	2.0	2.6	3.8
Without psychosis	0.5	–	–	–	–	–	–	–
Total	37.2	31.6	61.5	15.6	5.3	57.3	77.4	51.8

0.6% for the seniles and 3.7% for the arteriosclerotics to 48.4% for the manic-depressives and 39.3% for the alcoholics. Based upon all degrees of improvement the percentages averaged 34.3 for all female first admissions and varied from a minimum of 4.1 for the seniles and 14.2 for the arteriosclerotics to a maximum of 74.8 for the manic-depressives and 59.4 for the alcoholics.

As with discharges in general, percentages of recovery and of other degrees of improvement among all first admissions during 1944–48 did not differ significantly from those during 1909–10. Again this must be attributed to the influence of the growing proportions of first admissions with psychoses associated with advanced age. The percentages of recovery for the early and current cohorts of first admissions with psychoses with cerebral arteriosclerosis were 2.1 and 3.3 respectively. Among the seniles they were 0.7 and 0.6% respectively. If one considers all degrees of improvement, including recovery, the results are similar. This leads to the inference that first admissions with psychoses associated with advanced age now constitute a poorer physical selection and therefore have a lesser chance of recovery or of improvement.

Other groups have reacted more favorably, however. There were no recoveries among general paretics included in the cohort of 1909–10, compared with 5.6% of the current cohorts. All degrees of improvement in this group increased from 8.8% to 25.3%. Among manic-depressives the percentage discharged as recovered increased from 33.9 to 47.2, and all degrees of improvement increased from 46.2 to 74.8%. Dementia praecox is of special importance because it includes so large a percentage of the total admissions. Percentages of recovery in this group were 1.6 and 14.5 for the early and current cohorts respectively. For all degrees of improvement the corresponding percentages were 13.9 and 47.5 respectively.

MORTALITY

Table V summarizes mortality among the cohorts, by percent, during specified periods of hospitalization. Mortality was heaviest during the first year of hospitalization. An average of 27.4% of the male cohorts died during this year. Two-thirds of the deaths within the first year occurred during the first three months. Mortality decreased rapidly after this period and tended towards stabilization after the second year. Mortality was highest in the senile group, of whom 42.4% died within three months after admission. By the end of the first year 62.4% of the seniles had died. Mortality was also high among first admissions with psychoses with cerebral arteriosclerosis. A third died within three months and a half died by the end of the first year. Mortality was relatively high among general paretics, of whom a fifth died during the first three months and a third died during the first year. On the other hand, the percentage of those dying was low for the dementia praecox patients and relatively low for the manic-depressive and alcoholic groups.

Of the total female cohorts 15.4% died within the first three months of hospitalization. The percentage grew to 24.4 by the end of the first year. Mortality was highest in the senile group, of whom a third died within three months and 54% died within a year. Mortality was almost as high in the arteriosclerotic group, of whom 49% died during the first year. A fourth of the female general paretics died during the first year, less than the corresponding percentage for males. Mortality was lowest among the group with dementia praecox.

Of the male cohorts, an average of 39%

died within five years (see Table VI). The cohort with senile psychoses was far above this with 83.6%. Psychoses with cerebral arteriosclerosis followed with 72.1%. Slightly less than half of the male general paretics died within this period. On the other hand, the total mortality among male first admissions with dementia praecox averaged only 5.3%. Of the manic-depressive group 9.7% died within five years. The percentage for the alcoholic group was 11.1.

Of the female cohorts 36% died within five years. The total percentage of mortality varied from a maximum of 79.6 in the senile group and 70 in the arteriosclerotic group to a minimum of 5.2 for dementia praecox. Total mortality was 6.2% for manic-depressives and 9.7% for the alcoholic group. Of the female general paretics 38.9% died, compared with 47.2% of the males.

To complete the picture with respect to

TABLE V

Percent of first admissions to New York civil state hospitals dying during specified periods after admission, classified according to mental disorders

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months	18.0	19.3	3.7	34.0	42.4	5.4	4.2	1.3
Second three months	4.5	7.8	1.2	8.2	9.6	1.8	1.4	0.5
Third three months	2.8	3.9	0.9	5.3	6.1	1.3	0.4	0.4
Fourth three months	2.1	3.2	0.8	4.2	4.3	1.0	0.3	0.2
First year	27.4	34.2	6.6	51.7	62.4	9.5	6.3	2.4
Second year	4.8	6.1	1.5	8.6	9.3	2.5	2.7	0.8
Third year	3.1	3.4	1.7	5.4	5.6	1.8	–	0.6
Fourth year	2.1	2.2	1.0	3.6	3.6	1.3	0.7	0.9
Fifth year	1.6	1.3	0.3	2.8	2.7	1.1	–	0.6
				FEMALES				
First three months	15.4	15.6	4.5	31.7	32.9	5.4	3.4	1.6
Second three months	4.3	4.3	1.4	8.1	10.4	1.2	0.4	0.5
Third three months	2.7	2.7	0.6	5.3	6.7	0.7	0.6	0.2
Fourth three months	2.0	3.3	0.6	3.9	4.4	0.7	0.4	0.2
First year	24.4	25.9	7.1	49.0	54.4	8.0	4.8	2.5
Second year	5.0	4.0	1.5	9.2	12.0	1.8	0.6	0.7
Third year	2.9	4.7	0.7	4.9	6.2	0.7	0.6	0.7
Fourth year	2.1	2.7	0.4	3.7	4.3	0.8	–	0.7
Fifth year	1.6	1.6	–	3.2	2.7	0.4	0.2	0.6

mortality it is necessary to consider the rates per 1,000 annual exposures. These are given in Table VII. In every case mortality was highest during the first three months of hospitalization. The total male cohorts had a rate of 786.1 during the first three months. The rate decreased steadily during the remainder of the first year and averaged 296.2 for that period. The rate dropped after the first year and reached a minimum of 88.6 during the fifth year. The rates were highest in the senile group. The entire group would have died during the first year had the rate during the first three months been maintained. The rate dropped, however, and averaged 631.7 for the first year. It decreased during subsequent years but was stabilized after the second year. Rates were also high for the arteriosclerotic group. The rate averaged 529.6 during the

TABLE VI

Cumulative percent of mortality among first admissions to New York civil state hospitals during specified periods after admission, classified according to mental disorders

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arterio-sclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months	18.0	19.3	3.7	34.0	42.4	5.4	4.2	1.3
Second three months	22.5	27.1	4.9	42.2	52.0	7.2	5.6	1.8
Third three months	25.3	31.0	5.8	47.5	58.1	8.5	6.0	2.2
Fourth three months	27.4	34.2	6.6	51.7	62.4	9.5	6.3	2.4
First year	27.4	34.2	6.6	51.7	62.4	9.5	6.3	2.4
Second year	32.2	40.3	8.1	60.3	71.7	12.0	9.0	3.2
Third year	35.3	43.7	9.8	65.7	77.3	13.8	9.0	3.8
Fourth year	37.4	45.9	10.8	69.3	80.9	15.1	9.7	4.7
Fifth year	39.0	47.2	11.1	72.1	83.6	16.2	9.7	5.3
				FEMALES				
First three months	15.4	15.6	4.5	31.7	32.9	5.4	3.4	1.6
Second three months	19.7	19.9	5.9	39.8	43.3	6.6	3.8	2.1
Third three months	22.4	22.6	6.5	45.1	50.0	7.3	4.4	2.3
Fourth three months	24.4	25.9	7.1	49.0	54.4	8.0	4.8	2.5
First year	24.4	25.9	7.1	49.0	54.4	8.0	4.8	2.5
Second year	29.4	29.9	8.6	58.2	66.4	9.8	5.4	3.2
Third year	32.3	34.6	9.3	63.1	72.6	10.5	6.0	3.9
Fourth year	34.4	37.3	9.7	66.8	76.9	11.3	6.0	4.6
Fifth year	36.0	38.9	9.7	70.0	79.6	11.7	6.2	5.2

TABLE VII

*Rate of mortality * among first admissions to New York civil state hospitals during specified periods after admission, classified according to mental disorders*

PERIOD OF HOSPITALIZATION	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
First three months †	786.1	792.6	183.5	(1000.0)	(1000.0)	229.0	202.6	53.8
Second three months †	256.6	404.7	69.0	528.8	687.4	80.8	82.3	22.0
Third three months †	176.3	230.2	53.4	394.7	533.4	63.6	23.6	18.0
Fourth three months †	142.1	202.3	45.4	351.7	436.7	48.8	16.1	11.4
First year	296.2	351.8	77.0	529.6	631.7	99.8	73.0	25.5
Second year	103.4	122.6	30.0	226.9	285.3	45.1	64.5	13.3
Third year	109.3	114.1	55.7	227.4	267.2	66.7	–	15.1
Fourth year	96.7	95.7	45.7	209.2	266.4	64.9	87.0	24.4
Fifth year	88.6	67.4	13.2	211.3	300.0	70.2	–	18.6
				FEMALES				
First three months †	652.8	637.4	200.9	(1000.0)	(1000.0)	228.8	154.2	67.4
Second three months †	223.4	216.9	72.4	499.0	640.9	57.5	23.6	18.8
Third three months †	157.5	142.8	31.2	377.6	488.6	33.6	27.3	11.3
Fourth three months †	120.4	185.1	31.9	304.4	371.8	32.7	24.8	11.5
First year	257.9	266.9	78.0	500.3	550.6	84.4	53.7	26.8
Second year	98.8	72.0	29.8	225.4	285.6	32.1	13.2	11.0
Third year	94.2	130.8	29.1	193.8	236.6	25.0	47.3	16.4
Fourth year	84.9	101.0	22.4	195.1	222.2	31.7	–	18.0
Fifth year	74.0	61.9	–	202.4	190.0	20.9	55.6	15.8

* Per 1,000 annual exposures.
† On an annual basis.

first year but was stabilized at approximately 200 in subsequent years. Mortality was also high in the group with general paresis. The rate was 792.6 during the first three months, averaged 351.8 for the first year and declined to 67.4 during the fifth year. The lowest rates occurred in the group with dementia praecox. The rate was only 53.8 during the first three months and averaged 25.5 for the first year. The rates were lower in subsequent years, with no apparent trend. Mortality was also relatively low among the cohorts with manic-depressive and alcoholic psychoses.

The general trends of mortality were similar for females, although at a lower level. The female cohorts had a rate of 652.8 during the first three months and

averaged 257.9 for the first year. The rates dropped rapidly during subsequent periods, with a minimum of 74.0 during the fifth year. As with males, the female cohort with senile psychoses died during the first three months at a rate which, if continued, would have eliminated the entire group in less than a year. However, the rate averaged 550.6 for the first year and declined to a minimum of 190 during the fifth year.

The female cohort with psychoses with cerebral arteriosclerosis showed a similar trend, although at a lower level than the senile group. The cohort with general paresis began with a rate of 637.4 during the first three months, averaged 266.9 during the first year and fluctuated irregularly at a lower level during the remaining years. The cohorts with dementia praecox had the lowest rates of mortality, the rate of 26.8 during the first year contrasting strongly with the average of 257.9 for all female first admissions. The rates were also relatively low for the female cohort with manic-depressive psychoses.

TABLE VIII

Percent of first admissions remaining in continuous residence in New York civil state hospitals at end of specified periods after admission, classified according to mental disorders

END OF	*All first admissions*	*General paresis*	*Alcoholic*	*With cerebral arteriosclerosis*	*Senile*	*Involutional*	*Manic-depressive*	*Dementia praecox*
				MALES				
Third month	72.4	77.9	74.8	62.8	56.1	88.4	75.4	91.3
Sixth month	65.4	68.7	70.3	53.9	46.2	84.6	69.8	86.6
Ninth month	61.3	64.2	67.9	48.2	39.8	82.4	67.8	83.9
First year	58.1	60.4	66.1	43.6	35.3	80.9	66.4	82.0
Second Year	30.6	33.4	33.3	24.9	21.8	28.6	14.9	43.8
Third year	23.1	25.3	26.1	17.7	15.0	21.0	9.3	36.4
Fourth year	18.8	20.0	20.5	13.3	9.7	18.0	6.7	32.6
Fifth year	16.4	16.9	18.6	10.4	6.2	13.7	5.7	30.2
				FEMALES				
Third month	77.9	81.9	82.4	65.6	65.4	87.6	81.8	92.8
Sixth month	71.7	75.4	77.9	56.9	54.9	84.9	77.5	88.9
Ninth month	67.9	72.4	76.2	51.2	48.1	82.9	75.7	87.0
First year	65.0	68.3	74.6	46.8	43.3	81.3	73.9	85.7
Second year	32.8	38.6	29.0	25.9	28.6	32.3	16.9	44.9
Third year	25.3	29.3	21.2	19.7	19.9	25.1	9.2	37.8
Fourth year	21.4	26.0	15.1	14.9	14.8	21.4	5.8	35.4
Fifth year	19.4	23.9	12.3	12.4	11.3	18.7	3.9	34.9

The over-all rate of mortality for the current cohorts of 1944–48 exceeded that for the cohort of 1909–10. Thus 37.5% of the former died within five years, compared with 32.6% of the early cohort. As with rates of discharge, this resulted from the high rates of mortality among first admissions with psychoses with cerebral arteriosclerosis and senile psychoses. In fact, the current cohorts with the latter groups of psychoses showed higher death rates than those of 1909–10. Thus among the early arteriosclerotic group 69.1% died within five years, compared with 71.1% of the current group. The corresponding percentages for the senile cohorts were 76.1 and 81.6 respectively. However, other groups of mental disorders have shown improvement with respect to mortality. The most remarkable change was with respect to general paresis. Although the mortality is still high it has nevertheless been reduced from 70.4% of the early cohort to 43.1% of the current cohort. Improvement was also shown by the current cohorts with manic-depressive psychoses, the mortality having been reduced from 11.3% to 8.0%. The cohorts with dementia praecox showed a reduction in mortality from 8.9% to 5.3%.

The number of male patients remaining continuously on the books at the end of five years was reduced to 16.4% of the original total. Primarily because of the heavy mortality this was reduced to 6.2% of the cohort with senile psychoses and to 10.4% of the cohort with psychoses with cerebral arteriosclerosis. The percentage was even lower for the manic-depressive cohorts (5.7%), a consequence of the rapid rate of discharge among this group. The highest percentage remaining on the books occurred in connection with dementia praecox. This was owing to the fact that rates of discharge and of mortality were both low in this group.

The general picture was the same for the female cohorts. Of the total cohorts 19.4% were still on the books at the end of five years. This varied from a minimum of 3.9% for the manic-depressive cohorts to a maximum of 34.9% for dementia praecox. Because of the heavy mortality the final percentages were also low for the senile and arteriosclerotic cohorts.

Comparisons may be made with the cohorts of 1909–10. The latter, however, includes patients who were readmitted. On this basis there was little difference between the two sets of cohorts. The percentages remaining at the end of five years were 25.8 for the early cohort and 22.4 for the current cohorts. This was primarily owing to the influence of the arteriosclerotic groups. Because of increased mortality the percentages for the senile cohorts were reduced from 12.5 to 9.8. General paresis shows a remarkable change. Because of the great decrease with respect to mortality the percentage remaining at the end of five years was increased from 12 to 22.7. On the other hand, largely because of increased discharge rates the final percentages with manic-depressive psychoses were reduced from 15.6 to 12.8. In the case of dementia praecox the final percentages were reduced from 54 to 43.5.

Book Reviews

THE CRIMINAL, THE JUDGE AND THE PUBLIC: A PSYCHOLOGICAL ANALYSIS

By Franz Alexander, M.D., and Hugo Staub

Glencoe, Ill., Free Press, 1956. 239 pp.

This book was originally published in German in 1929 and translated into English in 1931, the translation being made by Dr. Gregory Zilboorg. This book, written by a practicing attorney and by a psychoanalyst, was a pioneering effort, bringing to the attention of the general public a description of the neurotic criminal with a severe and rigid conscience, which produced in him an unconscious sense of guilt.

In the revised edition Dr. Alexander, one of the authors, has added four chapters to the original text. These include an expert opinion given to a German court about the case of a 19-year-old double murderer; an expert opinion given on the case of a delinquent waiter under the title of "A Possessed Automobilist"; a chapter on "Psychic Determinism and Responsibility," and a chapter on "Psychiatric Contribution to Crime Prevention." Three of these four chapters have been published elsewhere.

In the preface to the revised edition Dr. Alexander emphasizes the difference in attitude of the American and the German medical and legal professions toward the criminal. In the United States considerable stress is put on the so-called "normal," non-neurotic criminals; this group of criminals has been largely neglected in the German literature, where the interest was primarily psychological. The American offenders appear to have more sociological than psychological causative factors and their anti-social acts are explained on the theory that they belong to a special community which has its own moral code which differs from that of the rest of society. These people are primarily considered as products of a special social environment, and their criminal behavior is not necessarily the outcome of unconscious neurotic trends reaching back into early childhood.

In this book, both in its original and in its revised edition, stress is laid on the psychological factors. Dr. Alexander writes: "The motivational studies in this book, however, apply also to this category of offenders [non-neurotic criminals], because both conscious and unconscious motivations operate in all human beings. It is only a difference in degree in which unconscious motivations contribute to normal and neurotic behavior."

The clinical material in the original version as well as in the revised edition makes fascinating reading and points out clearly the unconscious motivations for crime and the need that criminals have to suffer punishment.

In the chapter on crime prevention Dr. Alexander stresses that in the field of criminology there must be an integration of the biological, psychological and sociological knowledge if there is to be a scientific basis for crime prevention. He emphasizes that the public and those who deal professionally with criminals must be freed from emotional reactions towards the criminals which interfere with intelligent, scientifically founded penal procedures.

Dr. Alexander writes: "We must clearly make up our minds what penal principle we want to accept, and then we must treat the criminals accordingly from the time they are detected and arrested by the police until they are released from the prison. On the basis of psychiatric diagnosis, we will have to classify the prisoners into two large

groups: those who seem to us unimprovable and resistant to any psychotherapeutic approach, and a more promising improvable group. Towards the latter, we have to assume not a retaliatory but a purely therapeutic attitude. The unimprovable group must remain segregated from the rest of the society so long as they appear potential dangers.

"Psychiatry, however, will have no chance to contribute anything of real consequence to crime prevention as long as we have not freed our fundamental attitude toward the problem of criminality from those more primitive emotional reactions which have pervaded our whole penal system in the past."

The reviewer of this book heartily endorses these sentiments. In conclusion he is gratified that this book is being republished with additional clinical material; he hopes that it will have a very wide audience not only within the psychiatric and the legal profession but also among intelligent lay groups. Lay as well as professional persons can profit greatly from reading this very beautifully written, scientific contribution to the field of criminology.—FRANK J. CURRAN, M.D., Children's Service Center of Charlottesville and Albemarle County, Va.

MOBILIZING COMMUNITY RESOURCES FOR YOUTH

By Paul H. Bowman, Robert F. DeHaan, John K. Kough and Gordon P. Liddle

Chicago, University of Chicago Press, 1956. 138 pp.

The preface of this monograph states: "This is the third in a series of reports on the work of the community youth development program sponsored by the Committee on Human Development of the University of Chicago." The study was begun in 1951 and will continue for ten years. The basic query in this study is stated on page 3: "What can communities do to help prevent, or to solve, the personal and social problems of their children? How can existing research knowledge and clinically developed techniques be made available to local communities in a usable form? Can a youth development program be devised the operation of which will rely mainly on residents in the community and require a minimum of expenditure of funds?"

To find answers the University of Chicago sent four or more staff members trained variously in psychology, sociology, education and social work to live and work in a community of 40,000. A Quincy Youth Development Commission was formed from citizens in the community, and the trained workers might be called the "executive staff" of the commission.

There are many aspects of the study. One experiment is the selection and observation of groups of school children in the fourth grade who are either gifted, withdrawn or aggressive. Control groups were also carefully selected. Special services (remedial, therapeutic or enriched programs) were then provided for the experimental groups by the staff, or by others trained by the staff. The groups will be observed for a long period. The methods of selecting the sample of school children is described and the tests used in the process are printed in the appendix. This accounts for about half of the text of the monograph.

The remainder of the text describes how the staff group worked with teachers and community agencies and with volunteers to try to meet the needs of the children selected. Also the influence of the staff in the community has stimulated mental health activities in general. A Mental

Health Center has been started as well as a Mental Health Association. How this was accomplished is described and much careful analysis of the effective methods for community action is presented .

The project is worthwhile and the integrity of the data and of the workers appears unquestionable. The evaluation of the changes in the community after ten years as a result of these efforts should be enlightening, and may serve as a model for other communities who become concerned for the welfare of youth.—C. DOUGLAS DARLING, M.D., Cornell University Student Medical Clinic.

PROBLEMS OF ADOLESCENTS

By H. Edelston

New York, Philosophical Library, 1956. 174 pp.

This book is primarily a report on the author's experience in giving education in sexual matters to youth groups in England. In addition, while describing his method of procedure he presents his own philosophy of sexual control and expression.

The educational method used was to give a more or less formal lecture on sexual matters at the first meeting of the youth group and then to ask for written questions. The questions were answered during subsequent sessions. There was some free discussion during the periods when questions were answered.

About half the book is taken up with the presentation of a philosophy of sex arrived at by the author after years of psychiatric practice and youth group instruction. He appears to favor more dogma rather than less along religious and moral lines.

I think one could rightfully assume that Dr. Edelston was eminently successful in his personal youth group experiences. As anyone knows who has attempted similar projects it is almost impossible for the printed page to capture the personal equation of the lecture or the discussion. What may appear slightly pedantic in this book would probably make quite a different impression "on the firing line" of the group.

For adults who are looking for help in how to run discussion groups on the topic of sex education for youth, this book will be helpful. Many questions raised by the groups are presented in the book and some of these are directly answered. Many youths today know most of the facts about sex, but the opportunity to gain constructive sexual attitudes from well-adjusted adults is rare. Such attitudes are gained from personal contact, rarely from the printed page.

This book would be more properly named were it called *Sexual Problems of Adolescents.* Adolescent problems other than sexual are hardly mentioned.—C. DOUGLAS DARLING, M.D., Cornell University Student Medical Clinic.

HYPNOTHERAPY WITH CHILDREN

By Gordon Ambrose

New York, John DeGraff, 1956. 135 pp.

This is a small book. It is well written, readable and relatively free of psychiatric jargon. Directed primarily toward students and practitioners of Great Britain's National Health Service, it stresses the importance of emotional problems in practice and attempts to help the practitioner to feel more adequate in handling these problems by supplying him with a specific method.

The author repeatedly emphasizes the

value of hypnosis as though he were called upon to defend it. He cites the Subcommittee on Psychological Medicine Group of the British Medical Association: "Clinical use of hypnosis should be taught to all medical postgraduates training as specialists in psychological medicine." Hypnosis is a highly technical branch of medical psychology; one might question the wisdom of its wholesale application by the uninitiated. The author offers this method as an alternative to psychoanalytical methods, psychotherapy or play therapy "for superficial neuroses," but also includes such conditions as asthma, epilepsy and delinquency.

The first of three parts contains an historical account of hypnosis, its trials and tribulations. Interestingly, Freud is said to have abandoned hypnosis because he was gentle and unable to use a forceful tone of voice; thus he was incapable of hypnotizing some of his patients. Later, however, he predicted that its use would be reinstituted for superficial cases. The author gives in detail the method that he employs in hypnosis and describes its stages, stressing the rapidity with which it can be accomplished—seldom over a few minutes for the experienced person. This, he continues, "opens a channel up in the (child's) mind for the doctor's suggestion." The doctor is pictured as an authoritarian figure who tells the patient what to do. He allays tension, fear and worry by positive suggestion. This is the "establishment of rapport," which is used to reeducate the attitudes of the patients and their parents as well. Throughout the rest of the book, the author touches rather sketchily on the factors behind the tension and anxiety but stresses the importance of removing the tension first by hypnosis, almost as though this preceded the problem. (The) "main point is that the worried, anxious and tense child can seemingly be made happier by one interview." This can surely be accomplished by skillful people without the use of hypnosis.

Part Two deals with a segment of the psychopathology of childhood according to the following scheme: Depression, frustration and conflict lead to tension which, if untreated, results in chronic tension. "Tension is often the kernel of the child's difficulties." With tension as a common denominator, emotional illness is further classified into tension conduct (anxiety, delinquency), tension spasm (enuresis, asthma, epilepsy, stammering) and tension action (tics and habits, nail-biting).

Claims of considerable success in dealing by hypnosis with such problems as epilepsy, asthma and long-term stammering would seem extravagant and warrant considerably more confirmation than is offered. Most doctors who treat epileptics would hardly be willing to discontinue medication altogether for a trial of any kind of psychotherapy. In instances of tics and habits, the author employs hypnosis with the parents to relieve them of their own anxiety about the child. It would be a boon, indeed, if parental anxiety could be magically whisked away in a brief period but one is entitled to wonder whether any Coué or type of cooing (with or without hypnosis) can be relied upon to achieve this goal.

In Part Three there is a brief recapitulation of the preceding sections. The author summarizes what he considers the advantages of hypnotherapy over other therapies. Finally he lists a series of common-sense "do's and don'ts" of mental health as basic rules for parents (love, security, understanding, limitation, etc.) and admonishes the doctor to "study the patient in relation to the illness." Since this book is addressed to students and young practitioners, this is probably the best and most practical

part of the book, which closes with a quotation from R. R. Bomford in defining health: "A person's health depends first on the constitution he is born with, and then on the success he has in constantly adjusting either himself to his environment or his environment to himself so that a reasonable degree of harmony is maintained both within himself and between himself and the social and material world in which he lives."—LEONARD LESSER, M.D., Johns Hopkins Hospital.

COUNSELING AND PSYCHOTHERAPY WITH THE MENTALLY RETARDED

Chalmers L. Stacey and
Manfred F. DeMartino, eds.

Glencoe, Ill., Free Press, 1957. 478 pp.

As this book points out in any number of places, concern among professionals over the therapeutic amelioration of the conflicts, adverse attitudes and general emotional problems of the mentally retarded is of recent origin. Now is assembled for the first time, as far as this reviewer knows, a collection of papers on counseling and psychotherapy with the mentally retarded. Its scope is broad, encompassing psychoanalytic, directive, non-directive, play, sociodramatic, group, speech, occupational and even "industrial" therapy and an almost equal range of types of counseling, culminating in an important chapter on counseling with parents. The final chapter by DeMartino, one of the editors, offers observations (derived from obvious pertinent personal experience) on the use of this variety of techniques, and attempts to relate them to basic personality theory.

The book, except for introductory statements and the final chapter, contains abridgements of previously published papers. Some further space might have been saved by deleting references in many articles to the setting in which the therapy or counseling was attempted. It was usually unnecessary to have a description of the clinic or institution to comprehend the process reported. The articles, the editors acknowledge, "are not all of the same quality." The reviewer agrees! Certain high-quality sections are worthy of whatever commendation specific designation in this review affords. Such recognition should be accorded to Sarason, Pearson, Ackerman and Menninger, Cotzin, Fisher and Wolfson, Kanner and Reingold.

Descriptions of treatment of retardates with IQ's ranging from 50 to 105 are included. However, the obvious question about some of these cases categorized as "retarded" is probably no different from that any serious professional has about any diagnostic formulation or classification scheme presently used in connection with this class of persons.

The serious questions come in other areas. The very emphasis on the therapeutic processes tends to diminish the importance of relationships between the retarded and non-therapists. Attendants, teachers, parents, etc., providing sympathetic understanding and an opportunity for emotional growth, do effectively alleviate some emotional problems. The role of the therapist as consultant to the non-therapist, the rolling back of the therapeutic frontiers, are rarely stressed. In view of the obvious shortage of counselors and psychotherapists such stress is required. Finally, few authors raise serious questions about the therapeutic process. While the book intends to point out that the retarded can be helped by a therapeutic relationship, it might have been hoped that the authors would have been less accepting and expressed some need for research in the area of therapy itself.

The editors state they intended to include primary articles "useful to counselors, therapists, psychologists, psychiatrists, general medical practitioners, teachers, social workers, pediatricians, institutional workers, parents of the mentally retarded and lay persons who may be interested in the treatment of mental retardates"; the book will be useful in accordance with their ability to take from its pages. A greater usefulness, however, is the fostering of the process of returning to the retarded full status as individuals with personalities. Also, this text may stimulate investigation into the emotional problems of the retarded and the very nature of the therapeutic process itself.—MAURICE G. KOTT, Ph.D., New Jersey State Department of Institutions and Agencies.

PSYCHIATRIC EDUCATION AND PROGRESS

By John C. Whitehorn, M.D.

Springfield, Ill., Charles C Thomas, 1957. 48 pp.

Dr. John C. Whitehorn in the Salmon Lectures of the New York Academy of Medicine, November 30, 1955, presented in his address, "Psychiatric Education and Progress," a very comprehensive and stimulating discussion of the many different aspects of education and the progress of this education in psychiatry in particular.

This whole field presents a broad scope and, of necessity, the writer has had to delve so deeply into the multitudinous roles of educators that at times the wood appears to be lost in the trees. However, with skillful dexterity he has been able to unfold a continuing process of the progress over many decades, each of which has added scientific enlightenment, finally terminating in the writer's own wishful concepts of a totally integrated view of psychiatric education as we have it today.

This concept has emphasized the liberal approach to education (rather than the authoritarian) in which the author suggests that a multitudinous approach combined with dissent against doctrinaire biases, which are phobic defenses in areas of ignorance, can be the only path to future progress. He does not exclude the use of available concepts as the framework of an authoritarian foundation but rather emphasizes that authoritarian attitudes in the teacher should be replaced by liberal attitudes which give the student the feeling that he is "welcomed into a working group of senior staff," where he is permissively and stimulatively guided into experiences which become his greatest teacher. In this manner the emphasis is shifted from training, which may become automatic, to education, which is experiential and indelibly impressed by emotional experience.

In this connection, the use of the library, which contains an account of the historical developments of the presently available concepts, is brought into a more important role in the process of education, whereby a broader approach to the questions of research will be developed in the students of the future nurtured in this type of educational program. Dr. Whitehorn develops this thought from the fact that the microscope had become the arbiter of scientific validity, causing the field of believable pathology to become walled off, thereby excluding chaos but also excluding psychodynamics. Freud and his workers in turn became builders and defenders of doctrinaire dikes, emphasizing meaningful personal processes organized into mental mechanisms which set up a basis of understanding of human behavior. Thus general medicine and psychiatry became divorced from each other and lived in autonomy.

The present trend in education, however, is to cultivate a balanced approach and to break through these walls of autonomy so that the concept of integration can be brought into the spotlight, integration between research and service so that the scientific method can continue to question one's working assumptions, which will effectually break down the doctrinaire biases and supply education with further material which can be passed on to the practitioner in service. This concept the writer emphasizes in the question of residency training programs, which introduces further complications in terms of vocabulary, semantics and communication. This thought is elaborated in the idea that specialization is not totally concerned with the preparation and training for service functions, but that the process of education should be linked up with a concentration of investigative effort in special fields and that communication through the agency of publications and the liberal use of the library, as an educative experience, would be more creative and promote greater progress.

Dr. Whitehorn's lectures should be very stimulating to those interested in the field of education. This book is worthy of attention by all those interested and participating in the training of all physicians, but with special reference to those in psychiatry.—JOHN B. K. SMITH, M.D., Trenton.

PSYCHOLOGY, PSYCHIATRY AND THE PUBLIC INTEREST

By Maurice H. Krout, ed.

Minneapolis, Minn., University of Minnesota Press, 1956. 217 pp.

This book, which contains the statements of 16 psychologists and one psychiatrist, attempts to bring to public attention some of the problems that need to be resolved in the relationships between these two professions. As can be seen from the predominance of psychologists contributing, the book is largely devoted to the statements of experienced psychologists. Dr. Paul Huston, the one psychiatrist contributing, offers two statements. They are more than his own. They are, as he states, "nearly the consensus of feeling in American psychiatry today." Here he refers specifically to the "independent practice of psychotherapy by psychologists." This is the central issue of controversy between the two important disciplines.

Whether this book will help to clear the air on this issue or only serve to bring into the open this controversial question remains to be seen. The positions of each group are clearly stated. The public, to whom the book is addressed, already confused about the differences between a psychiatrist and a psychologist, may be even more uncertain after reading these statements from individual psychologists, several of whom are actively engaged in the independent practice of psychotherapy.

Running through most of the statements is a positive note and that is the fact that the two professions, with a different background of training, have a great deal to contribute to each other. As they work together in hospitals and clinics, the service they build is stronger because of their integrated efforts. Confusion gets into the picture when the valuable differences are erased as each discipline competes for its place in the therapeutic function which, by tradition and legal sanction, belongs to the medically trained psychiatrists.

There is one important point of agreement—all who undertake psychotherapeutic responsibility must have special and carefully supervised training.

The book would have been better bal-

anced if more psychiatrists had been asked to contribute. Sixteeen to one is not a good balance, particularly in view of the title.—FREDERICK H. ALLEN, M.D., Philadelphia

NONPARAMETRIC STATISTICS FOR THE BEHAVIORAL SCIENCES

By Sidney Siegel

New York, McGraw-Hill Book Co., 1956. 312 pp.

In the past the behavioral scientist has had relatively little choice in the type of statistics he has been able to employ. He was forced to use parametric statistics, *i.e.*, he has had to assume that his data emanate from a population which gives rise to a normal distribution (this can be roughly described as a bell-shaped curve where the middlemost scores occur most frequently in the population and the extreme scores, both high and low, occur less frequently). Since investigators have found distributions which were obviously non-normal, a need arose for a type of statistics in which the normality assumption did not have to be made. Nonparametric statistics, or distribution-free statistics as they are otherwise known, are essentially of this nature. Now the time has finally come in the development of nonparametric statistics when the single chapter devoted to this subject matter no longer suffices to describe all of its techniques. Siegel's book makes available in one place many of the nonparametric statistical tests and the tables of significance levels necessary for them.

With the advent of this book no behavioral scientist should any longer feel compelled to assume an equal interval scale or a normal distribution when all evidence available contradicts these assumptions, since such assumptions are not necessary for the proper use of nonparametrics; he should not hesitate to apply a statistical test because his data are in the form of a nominal scale (diagnostic classifications, for example), since many of the nonparametric tests of significance were made for exactly such cases; finally, he should not shirk the task of applying statistical tests for want of time or computing machines, since the availability of tables and the ease of computation of the nonparametric tests make them less time-consuming than the classic statistical methods.

The content of the book is quite extensive in terms of the types of problems for which tests of significance are made available. Siegel very commendably takes time out from telling his readers what to do with numbers to teach them to recognize the kind of numbers they are dealing with. A part of the book deals with the differences between nominally ordinal, equal interval and equal ratio scales and these distinctions, once made, are later utilized to make the reader aware of which statistical tests can be used for what scales. Siegel's book makes available the analogues of most classical parametric significance tests. Just to give an example, the t test for the difference between two independent samples is matched by the following nonparametric techniques: the X^2 test, Fisher's exact probability test, the median test, the Mann-Whitney U test, the Kolmogorov-Smirnov test, the Wald-Wolfowitz runs test and Pitman's randomization test. Furthermore, the Moses nonparametric test of extreme reactions deals with aspects not even detected by the t test, which is sensitive to shifts in location or in dispersion rather than to extreme scores.

This great number of nonparametric tests available for estimating significance of difference makes it possible almost to tailor a test to the experiment or analysis being

undertaken by an investigator. Each test in the book is described in terms of its function and rationale, computational methods with examples, summary of procedure, power of the test and some references. The test is compared to all of its parametric and nonparametric equivalents and advice is given about when to use each one.

In addition, Siegel's book contains a storehouse of 21 tables which are difficult to come by within the confines of any other single book.

Some room for improvement is left in this book, however. The author gives no practice problems for the student. These would certainly be helpful. The explanation for the computation of the rank order correlation coefficient *tan* is inadequate because no instructions are given for what procedure to follow when both variables contain tied ranks. While a great deal of emphasis is given to significance levels, no effort is made to explain procedures for computing confidence intervals, which are important for providing the experimenter with estimates of population measures of central tendency, differences between populations, *etc.* Finally, mention must be made of the omission of Olmstead and Tukey's corner test of association, a very simple correlation technique which combines the advantage of seeing a relationship graphically with the precision of a significance test.

In conclusion, this reviewer commends this book as a very much needed reference book as well as a good textbook for the omnipresent non-mathematically trained student. For the mathematically trained behavioral scientist a book like Fraser's might serve to clarify the basis of the tests discussed in a practical way by Siegel.—DR. KURT SALZINGER, New York State Department of Mental Hygiene

A FOLLOW-UP STUDY OF WAR NEUROSES

By Norman Q. Brill, M.D., and Gilbert W. Beebe

Washington, D. C., Veterans Administration, 1955. 393 pp.

This book represents a tremendous research based on clinical and statistical techniques, to advance our knowledge of war-time neuroses. Approximately 1,000 Army and Navy enlisted men who were admitted to military hospitals during 1944 with a diagnosis of psychoneurosis constitute the samples studied.

The study concerns itself with (1) the characteristics of the sample, (2) how they differed from the general military population before and during service, (3) the circumstances associated with their breakdown, (4) the course of their illness, (5) the quality of any further duty performed, (6) what happened to them after they left service, and (7) how they were five years later.

The book itself is not what one would call good reading for it is essentially a series of 271 statistical tables interlarded with verbal descriptions of what the tables show. Brief summarizations are included here and there and for those who are not doing related research probably represent the most informative part. The statistical data is undoubtedly of considerable value for other researchers, and its precise presentation indicates the great care that went into its accumulation.

Data gathered from the sample support the following interesting points:

1. Psychiatric screening at induction is of little or no value. It may do more harm than good—by eliminating men who could

serve successfully—if it attempts to eliminate any but the obviously unfit, such as psychotics.

2. The widely held opinions that military service will usually aggravate a civilian neurosis and that the civilian neurotic can be of no value to the military establishment are largely untrue, yet many medical men and even psychiatrists continue to hold these beliefs.

3. About 60% of this sample were medically discharged for psychiatric illness. Those who were given a chance for another duty assignment did reasonably well.

4. At least half of the cases discharged could very likely have been of further use in the services if proper assignments had been found for them.

5. A man who is discharged on psychiatric grounds appears to be twice as apt to be sick on follow-up as an identical man who was returned to duty and eventually discharged at the convenience of the government.

6. At the time of separation from the service two-thirds of the men realized their illness was emotional in origin.

7. Following separation from service only 36% of the men sought any kind of medical treatment for the manifestations of their emotional disorder. Only 15% sought or received psychiatric treatment.

8. On follow-up five years after service 40% of the men were drawing VA compensation for psychiatric disability, with the median award 20%, which was equivalent to $33 per month in 1954.

9. In the psychiatrists' opinion at follow-up, about 20% of those receiving compensation were deleteriously affected by it.

10. As seen five years later the net effect of breakdown in the service was not so great as might be expected. There is relatively little change in those who were previously normal or overtly neurotic, and a moderate worsening in those with personality disorders, neurotic traits and suggestive neuroses.—ALAN CHALLMAN, M.D., Minneapolis

RETARDED CHILDREN CAN BE HELPED

By Maya Pines

Photographs by Cornell Capa

Great Neck, N. Y., Channel Press, 1957. 159 pp.

The ten chapters of this book give the reader a broad understanding of what is being done and what might be done for retarded children. Based largely on the activities of the Association for the Help of Retarded Children (the New York state division of the National Association for Retarded Children), the work is devoted to the remarkable achievements of organized groups of parents of retarded children in developing needed services.

The story form is used throughout to describe the growth of parent organizations, the modern clinic, the need for public education for both "educable" and "trainable" children, social guidance and the vast possibilities of proper vocational training and placement.

Many practical suggestions are made for enlisting cooperation, securing funds, organizing and extending services. The remarkable work of parents in Nassau County, N. Y., is used as a striking example of what could be accomplished elsewhere.

The last three chapters describe institutions, the daily life, the changes made to reform a poor institution and what a progressive institution—the Southbury Training School—is accomplishing.

Although the book does not attempt to cover the whole field of retardation, much general information helpful to parents is skillfully worked into the text. Handsome photographs illustrate the material and add greatly to the value of the volume.

The book could not fail to give hope and courage to parents of retarded children. It also conveys a strong appeal to join other parents in the successful movement to provide more opportunities for the retarded in the home community.—KATHARINE ECOB, New York City

LOVE AND MARRIAGE

By F. Alexander Magoun

New York, Harper & Brothers, 1956. 475 pp.

After numerous reprintings since its original publication in 1948 *Love And Marriage* has now been revised. Dr. Magoun has expanded and reinterpreted his book in the areas of the nature and meaning of love, emotional maturity, and divorce, as well as given the reader the benefit of the information he has gleaned from young people as he has lectured, counseled and taught throughout the United States. In addition to this, he has incorporated into his revised book the feeling and thinking of his late son, Richard, who collaborated with him in his earlier edition.

The emphasis in this new edition, as in the earlier volume, is on "the importance of knowing what one really feels and the effect of childhood training on this knowledge." In his expanded opening chapter, "The Nature of Love," Dr. Magoun has underscored and highlighted with profound insight and clarity the concepts that "the more warmth and sincerity of affection a person has for himself, the more he can bestow on others"; that "any self-sacrifice which damages the personality or harms the genuine togetherness of people is not virtue"; and that "togetherness involves the sharing and respect for two separate individuals each fulfilling potentialities of his own personality." For students an additional and very useful feature of this first chapter is the comparison drawn between "romance" and "love" in terms of feelings, action and thought.

A new chapter on emotional maturity became imperative, Dr. Magoun says, because of his "experience and increased realization of the solid relationships between emotional maturity and love." This chapter deals with some of the manifestations of maturity, definitions, sources, and growth through childhood. The "easy road to maturity is to be brought up by parents who are mature." The latter part of the chapter is somewhat different from other treatments of the subject in that it suggests some practical steps in dealing with emotional immaturity in courtship and marriage.

In the chapter on the pre-marital sex problem there is little change from the earlier edition, although there are added statistical studies on sources of sex information for adolescents, additional comments on the Kinsey data, and some illuminating case material amplifying the discussions.

The chapter on divorce has been brought up to date and reflects the newer attitude on the feelings about divorce and the changing approach toward the legal treatment of divorce cases. The attitude expressed may be summed up by the following quotes:

"What right have we to expect all marriages to succeed when no other human relationship is perfect?" If there is "no loving relationship there is no marriage worthy of name;" and "There should be some dignified respectable way of terminating it." He points out that whereas the theory of no "mutual consent" as grounds for divorce remains, "in actual practice our courts are coming closer and closer to the old Roman idea of divorce by mutual consent. The so-called defendant merely puts up no defense." He cites the concern of the Toledo and Cincinnati courts over "whether the marriage can be saved" and the 1951 Ohio law "requiring professional investigation of the family situation wherever children under 14 are involved."

One of the new, interesting and useful features of the edition is the appendix, which includes 427 questions that have been asked the author during his teaching experiences. These questions are tabulated under subject headings. For those who teach and counsel young people in any setting these questions will be familiar and will remind us of the needs and interests of those we serve. The first five questions in order of frequency are:

1. Can an interfaith marriage be happy?
2. How do you know when you are in love?
3. How far should an engaged couple go in sexual behavior?
4. How can I learn to be emotionally mature?
5. Questions on birth control.

It would have been helpful if Dr. Magoun had expanded the topic of interfaith marriage since it was the number one question reported as reflecting student need and interest. Some readers may be disappointed because of the limited amount of current research reported; however, upon closer examination it is clearly evident that the book is communicating the experiences of the practitioner and that research findings are interpreted through the eyes of the author.

Those who have used Dr. Magoun's earlier editions of *Love and Marriage* will welcome this new edition, which includes fresh insights and a re-emphasis on the importance of personal growth and the interdependence of family members. It is an excellent book for those preparing for marriage, for the newly married and for students of family life, teachers, ministers, counselors and all who are interested in strengthening personal and family life.—MRS. DOROTHY T. DYER, University of Minnesota College of Science, Literature and the Arts

FINAL CONTRIBUTIONS TO THE PROBLEMS AND METHODS OF PSYCHOANALYSIS: SANDOR FERENCZI, M.D.

By Michael Balint, M.D., ed.

New York, Basic Books, 1955. 447 pp.

This volume completes the publication in book form, in English, of all Ferenczi's important papers. There remains unpublished his correspondence with Freud and the scientific diary that he kept during the last year of his life.

The editor notes that the volume contains (a) papers written after *Further Contributions to the Theory and Technique of Psychoanalysis,* (b) posthumous papers, notes and fragments, and (c) papers which were omitted from *Further Contributions.*

There is a comprehensive bibliography which "enumerates in chronological order all Ferenczi's papers published in English, giving in each case the volume and page numbers where the paper may be found" and including references for the obituaries and appreciations of Ferenczi. The index also covers all books and papers by Ferenczi published in English. There is an introduction by Dr. Clara Thompson.

This volume is remarkable and delightful in that it gives the reader a series of papers written from 1908 to 1933 in which can be seen the stages in the development of the writer's thinking and the variety of topics in which he was interested.

It would be an injustice to try in a brief review to discuss the content of the many longer papers and shorter notes. They are all Ferenczi. They reveal the "novelty and boldness" of his intuitive insights and the unfailing human kindness and respect for persons which we associate with him and with his writings. Many of his ideas are now quite familiar to us as they have been developed and extended by recent workers. It is impressive how many of these ideas were novel and bold when he offered them.

All those who know Ferenczi's work and writing will want to have and read these *Final Contributions,* regretting only that they are final and that he did not live to pursue further his researches.

All psychoanalysts should know Ferenczi, and indeed all psychiatrists will find his writing instructive and provocative of interest in the working of the human mind.

This reviewer cannot refrain from mentioning one paper in this volume. It is "Confusion of Tongues between Adults and the Child." Written and published in 1932–33, it is a brilliant forerunner of the current papers by several authors upon the childhood traumatic experiences of schizophrenic patients. Ferenczi does not refer particularly to schizophrenics but he does describe vividly the situations which in extreme forms result in this disorder. And he offers interesting ideas about treatment, ideas not even yet fully understood but still challenging.

Dr. Michael Balint deserves great credit for his editorial achievement and for the adequate translations presented.—LEWIS B. HILL, M.D., Towson, Md.

PROBLEMS OF FAMILY LIFE AND HOW TO MEET THEM

By Maxwell S. Stewart, ed.

New York, Harper & Brothers, 1956. 227 pp.

Regular readers of the popular Public Affairs pamphlets will recognize much of the material presented in this book as having been published previously in pamphlet form.

Ten important issues related to the everyday problems of family living are briefly but competently dealt with in this volume. Interfaith marriages, marriage adjustments, in-laws, broken homes and working wives and mothers are frankly discussed in a readable and helpful fashion.

The chapters dealing with handicapped and retarded children, the role of grandparents, aging and retirement are particularly sympathetic and constructive.

As a human relations guide for adult family members this should be a useful handbook for problem solving. Teen-age members of the household also will find sound guidance in this uncomplicated and honest volume.—MRS. ELIZABETH S. FORCE, Toms River, N. J.

APPROACHES TO THE STUDY OF HUMAN PERSONALITY

AN EVALUATION OF THE NEWER PSYCHOPHARMACOLOGIC AGENTS AND THEIR ROLE IN CURRENT PSYCHIATRIC PRACTICE

APPLICATION OF BASIC SCIENCE TECHNIQUES TO PSYCHIATRIC RESEARCH

Psychiatric Research Reports 2, 4 and 6

Washington, American Psychiatric Association, 1955, 1956. 2, 176 pp. 4, 129 pp. 6, 211 pp.

The three volumes to be covered in this review have little in common except the social structure that brought them into being. It is difficult therefore to present a succinct review of them. In view of this I will first comment on each of them. I will then make some general remarks summing up my over-all impressions.

Report No. 2 is devoted to a study of the human personality. It is divided into seven symposia, which range in orientation from psychoanalysis to cybernetics and include in their sweep biochemistry, semantics, communications theory and other approaches. A common theme is followed, at best, only within each of the seven divisions. The over-all effect is that of a collection of papers in a scientific journal. Thus a general evaluation of the volume is impossible; comments must be restricted to individual contributions.

The volume begins with a section entitled "Psychoanalytic Approach" containing a brief paper by Erich Fromm on free association and papers by Fuente-Muniz and Millan. The two latter contributions have little to do with psychoanalysis. Fromm's contribution, a vague and general discourse on free association interspersed with occasional critical comments on "psychoanalysis," is disappointing. Sample: "I, myself, am not an orthodox psychoanalyst" (p. 3). He hastens to add that he is critical of some practices in "non-orthodox analysis" too. We are also told that "we all are crazy, we all are neurotic, we all are children, and the difference between us is only of degree" (p. 5).

The biochemical approach is presented in a 2-page summary. This is a synopsis of the work of Roger J. Williams, which has been presented in detail elsewhere.

Two papers by Bateson and Haley follow. These are distinguished by their excellence. Both deal with the subject of play and fantasy from the viewpoint of communications theory and symbolic logic. The work reported has interesting applications to all communicational situations and particularly to the process of psychotherapy. In a recent publication (*Behavioral Science*, October 1956) Bateson and Haley (with Jackson and Weakland) have applied their observations and ideas to the problem of schizophrenia. This work is stimulating and important.

Anatol Rapoport contributed two papers, one entitled "The Role of Symbols in Human Behavior," the other "Technological Models of the Nervous System." Both are lucid, if somewhat elementary, expositions. The latter essay was published earlier in *ETC. A Review of General Semantics* (Vol. 11, No. 4, 1954.)

Finally, the volume includes papers concerned with experimental psychological studies, a "holistic" essay by N. S. Kline entitled "Toward a Theory of Man," and a rambling but stimulating essay by the anthropologist Hsu. Each of the seven symposia is followed by a discussion which

in the opinion of this reviewer adds more to the length than to the value of the volume.

Report No. 4 is devoted to the study and evaluation of tranquilizers. This volume is divided into four sections. The first symposium deals with physiological and pharmacological studies, the second with clinical evaluations, the third with clinical complications of the drugs and the fourth with the role of drug therapies in current and future psychiatric practice. A large mass of data is presented. This will be of more interest to those who tend to view psychiatric syndromes as reflections of diseases of the brain than to those who place greater emphasis on psychological (social, symbolic, etc.) considerations. As to the possible value of this work, I can do no better than to quote the words of one of the discussants. David Rioch stated: "These psychopharmacologic experiments may or may not contribute to a better understanding of psychiatric problems—a question which is still unclear. They do provide, however, many data of considerable importance to our understanding of the functions of the body" (p. 32).

From a scientific point of view, the high-point of this volume is a brief essay by Masserman and Pechtel on an experimental investigation of factors influencing drug action. This is a valuable piece of work, even though the authors' main conclusion—to be quoted presently—would be more interesting as a premise upon which one might base inferences than as a conclusion. It is that "it is impossible to state the effects of any drug on any organism without considering the latter's genetic characteristics, past experiences, biologic status, and perceptions about, motivations toward and evaluations of its current physical and social milieu" (p. 110). This statement borders on a truism, but the fact that the authors found it worth making suggests that it is an apt commentary on the neglect of such considerations in many current investigations on "psychopharmacology."

Report No. 6 presents a variety of papers organized around the theme of the application of basic science techniques to psychiatric research. Contributions range from neurophysiology, through tranquilizers and psychoanalysis, to philosophy. While several of the papers are of a high caliber, few present observations or ideas not previously reported elsewhere. In this volume, in contrast to the other two, the discussions are, by and large, more interesting—at least in this reviewer's opinion—than are the papers themselves. Among the latter, Kaplan's philosophical comments on the problems and methods of psychiatry is particularly rewarding.

I would like to conclude with a few general remarks concerning this series of publications. Each volume represents the proceedings of one of the regional research conferences of the American Psychiatric Association. Although each conference is organized around a special topic, the contributions range widely both as to content and value. Indeed, by and large there is so little continuity from paper to paper that each volume is best viewed as a separate issue of a psychiatric journal. Another serious criticism of the series is that many of the papers do not report on new work or new ideas. Usually this means that the work has been previously reported elsewhere, either in *toto* or in large part. Since there is general agreement that there is already a prohibitively large quantity of published material with which the serious student of psychiatry must acquaint himself, such duplication is clearly undesirable.

—Thomas S. Szasz, M.D., State University of New York College of Medicine

Editorial

The National Congress of Parents and Teachers, through the leadership it has given to its constituent PTAs, has exerted a tremendous positive influence on the health of the school child in the United States. Through its summer round-up it has assured the school that it can begin its work with a healthier child. The uncertain care of the child in his preschool years has, to the degree that parents cooperate, been compensated for by these round-ups.

It took some time to embody in the round-up the concern for the whole child, including not only his physical condition but his healthy behavior as a person—that is, his mental health. This delay was by no means a lack of interest or intent on the part of the National Congress. It was much more the inability of experts to come up with evaluating techniques that were within the time and financial limits of the round-up. It was a problem to discover the crucial things about the child without entering into costly and time-consuming individual psychological study. The National Association for Mental Health has given continuous support to this effort over the years.

But the concept of the whole child is more than is gained from a total cross-section just before entering school. The whole child includes not only a consideration of one day but of all the days since his birth. It includes also his home and all of its impacts. Only by a continuous appraisal beginning before birth, but even more by a continuous effort to reduce his limitations and increase his assets, can he really enter school in the best condition. In fact, only in that way can he begin a lifetime responsibility of continuous but reasonable concern for his own well-being and that of his family. This is a new look for the National Congress.

At a recent meeting the National Congress of Parents and Teachers took formal action on this new approach in two ways:

I. It adopted a policy supporting and encouraging a program of continuous health supervision of children from birth through their school experience, rather than only a program of single appraisal on school entrance.

II. It decided to recommend to its local units a promotional and educational program that will tend to bring children and their parents into effective contact with the health resources of the community. Whenever possible, said the Congress, these should be the physician and dentist who normally serve that child or family, whether they work in private practice or in a community health service.

This is the logical outcome of the round-up. It is the kind of approach in which a mental health effort can find itself. A watchful eye can pick up out of a child's behavior that which may be a warning of mental ill-health. We can afford to keep an eye on these potential warnings to see whether they are danger signals or merely a part of the discrepancies of growth which the child's inherent restorative capacities may balance. Only a continuous observation can reveal the differences between this and something that demands more aggressive treatment. It can be based upon watchful waiting, made wholesome by faith in human potential and resort to treatment when treatment is needed.

The mental health organizations are behind this trend. The local mental health associations throughout the country have worked with PTAs in helping them plan programs and in helping themselves to reach a broader and interested public. They will be challenged to cooperate even further under the new objectives.

Notes and Comments

CARE OF THE MENTALLY ILL IN GREAT BRITAIN

During the past several years we had heard glowing reports of changes being made in methods for the care of the mentally ill in some areas in Great Britain.

One is tempted to try to determine how these changes began. The question is asked: "Why Britain?" It perhaps may be that the soil was fertile in Britain as a result of social and economic changes. It may be that inspired leadership was available. It is more probable, however, that a combination of forces has set the wheels in motion. One factor which cannot be denied is nationalization of health services. From my own observation, I feel that this was a contributing factor which has helped to integrate all medical facilities making available to psychiatry free use of facilities not previously available. I do not intend that this should mean an endorsement of nationalization of health services, as I am sure that there are defects in this system which may outweigh the present advantages, particularly in fields other than psychiatry. A progressive program of this sort certainly is more easily attained in a society the members of which come from a uniform culture and have attained a high degree of sophistication and civilization. The fact that conditions were right in Britain does not, in any way, indicate that a major part of this program cannot be adopted in other societies. It may take longer in other places but I firmly believe that a pattern has been set which will result in profound changes in mental health attitudes in the United States as well as in other countries.

Let us first deal with the progress that has been made in liberalizing and normalizing the care of the patient in the mental hospital. It is my observation that considerable progress has been made in this area in Britain. The pioneering work of Rees and Bell in opening up the mental hospital is gaining wide acceptance. We have heard much in recent years in the lay and psychiatric press of the "open hospital." Before visiting two of the open hospitals in England, I was somewhat skeptical of the totality of this program, feeling that even under the best circumstances there were certain wards in every mental hospital that would need to be secured for the welfare of the patients as well as the public. After spending several days at Warlingham Park Mental Hospital and at Mapperly in Nottingham, I am convinced that it is possible to operate some mental hospitals as completely open institutions. I am still not convinced that every mental hospital in every state can run a completely open program. It seems evident, however, that we should be able to extend this program very greatly in this country. The fact that the British mental hospitals are small, usually averaging around 1,000 beds, makes opening of the hospital somewhat easier. It is not to be understood that opening a mental hospital can be accomplished in a brief period of time. Much education of the personnel, patients and general public is necessary, and steps must be taken gradually. Rees has spent many years developing this program at Warlingham. The "open hospital" cannot exist as an entity alone. It is rather a symptom of a vastly improved

Dr. Francis J. O'Neill, of the Central Islip State Hospital in New York, was one of six state hospital directors who recently made a 4-week tour of British mental institutions. His observations, presented April 5, 1957 at the annual meeting of the New York State Society for Mental Health, are reprinted from the June 1957 issue of the *Mental Hygiene News* (New York).

community mental health program. To unlock the doors alone would bring little progress. It must be incorporated into other progressive steps aimed at integrating the mental hospital with the community. From my observations and conversation with the British leaders, I am now convinced that opening the mental hospital ward has a definite therapeutic value. It has been their experience that the conduct of the agitated and disturbed mental patient shows great improvement as the result of opening up of the ward. It must also be recognized that opening the hospital alone is not the answer. An intensive treatment and activity program must accompany the gesture of unlocking.

In the "open hospitals" in Britain, activity and therapy is the keynote. Habit training of regressed patients must be instituted. Whenever a ward is opened, physical, social or therapeutic activity must be provided. The open door does not provide unlimited license for the patient to do whatever he wishes. He still must be subject to rules, and supervision cannot be discarded. One by-product of the "open hospital" is that of permitting a concentration of ward personnel during the daylight hours. Many nurses, formerly on duty at night, can be reassigned to more productive hours as it is possible to use a skeleton staff for supervision at night. The opening of the hospital pays many dividends in the form of improved conduct on the part of the patient, increased release rates, improvement in the morale of the staff, employees and patients as well as the removal of an air of "Bedlamism" from any part of the hospital.

We were greatly impressed by attempts being made to normalize the existence of the daily life and the surroundings of the patient in the hospital. Wards are small, tastefully decorated with a profusion of cheerful colors throughout. The floors are covered by rugs. Wallpaper is used throughout. Window guards are absent. Nowhere in Britain did I see a ward with a wooden bench or unupholstered chairs. The ward furnishings resembled those used in British homes and do not have an institution stamp upon them. An attempt is also being made in some areas to get away from institutional type of clothing for patients. Purchases are often made locally and the patient is able to pick out his own clothing from a good selection of well-cut and tailored garments. This alone greatly improves the morale of the patient as he does not stand out from other citizens when he is away from the hospital.

There are some hospitals in Britain where the patient government has become quite prominent. We did not have an opportunity to study this aspect of the situation but I would like to point out that in those hospitals where the environment of the patient has undergone radical improvement, participation in the management of the ward is an accepted procedure. I regret that time does not permit me to go into further detail concerning the steps being taken in England to normalize the environment of the mental hospital. One more example, however, will serve as an illustration. In several hospitals, Darby and Joan clubs have been organized. These seem to resemble the British pub without the saloon atmosphere. They are usually quartered in a central area in the hospital and provide a club open to patients during certain day and evening hours. Here the patients mingle freely with a minimum of supervision, provide their own entertainment, and run their own affairs. The obvious advantage of such socializing programs need not be stressed. This is but one of the many steps being taken to make the mental hospital as much like a normal British community as possible.

Let us now deal with progress being made in integrating mental hospitals into the community mental health program. This has been a fond wish in American psychiatry for a long time. Definite steps have been taken in this direction in our own state as well as in other areas of the country. One only has to note the development of the community mental health program, the day hospital program and other pioneering steps in our own state. In Britain, circumstances seem to be highly favorable to the development of a community-oriented mental health program. I am going to use the Warlingham Park program as an example which I believe is not completely typical of all such programs in Britain but is one of the first and, I believe, one of the most successful of such programs.

This hospital provides a total mental health program for the Croydon area, a county borough outside the city of London in Surrey. The hospital with approximately 1,000 beds services an area with a quarter of a million population. It provides all of the services to this area. Approximately 800 patients are admitted each year and 90 per cent of them are voluntary patients. The duration of stay in the hospital is measured in weeks rather than months. The psychiatric staff of the hospital is responsible for staffing the other mental health facilities in the Croydon area. These other facilities are important in providing care for the mentally ill and in decreasing the number of patients admitted to the mental hospital. There is a close relationship between the hospital and the office of the medical officer of health, who is the public health officer of the district. This cooperation makes it possible to provide care in the community for many patients who otherwise would be sent to the mental hospital.

If a patient is suspected of being mentally ill in Croydon, a member of the hospital staff visits the patient in his home with his own physician. If it is felt that the patient needs psychiatric care, the last thing considered is admission to the mental hospital. A program, tailor-made for the patient, can usually be provided by the use of day hospital facilities, outpatient clinic visits, welfare home assignment, treatment in the psychiatric unit of the general hospital, or home care. In most cases, it is found that the emotionally disturbed patient can be successfully treated in one of these other facilities. The close integration of health services in Britain makes it possible to provide these other health facilities. In Croydon, the mental hospital is not remote from the area served and its medical staff is well acquainted with the problems of individual patients whether they be in or out of the hospital. If it is decided that a patient needs care in the mental hospital, treatment is instituted rapidly and return to the community is expedited by the wholesome atmosphere of the hospital. When the patient leaves the hospital, he may take advantage of any of the health facilities present in the community during his convalescence. Vocational counseling and retraining is made available as a part of the local health program. This type of program is operating in other areas of Britain with equal success. There are still some places, however, where a community program has not been developed but the trend seems to be in that direction.

There is a growing tendency in Britain to care for the elderly mental patient outside of the mental hospital. When one visits hospitals such as Warlingham Park and Mapperly, very few senile patients are seen. This is accomplished as a result of the integration of health services and by the variety of facilities available outside of the hospital. Day hospitals, welfare homes, occupational centers play an important

part. The day hospitals provide care for the senile patient during the daytime when the family may be working and permits him to live in his normal environment at night. The British have found that this works quite well as the family gets several hours of relief during the day and do not object to sharing part of the burden of the care of the elderly patient.

The number of patients in mental hospitals in Britain is decreasing and overcrowding has been largely eliminated as a result of this enlightened program. It is impossible to say whether or not the per capita cost of care has been decreased. It is very difficult to draw conclusions from any statistics available. The voluntary status of the majority of patients in these British mental hospitals results from all of the facts already discussed and did not come about as a magical transformation.

Before leaving the discussion of the mental hospital, I would like to say briefly that British law is liberal concerning the release of mental patients. The next of kin is permitted by law to discharge the mental patient except in those few instances where the medical superintendent is willing to certify in writing that the patient is dangerous and unfit to be at large. This has placed a certain responsibility on the family, and, in England at least, expedites the release of patients.

One of the most notable features of the British system is the quality of ward personnel. Their mental hospital wards are manned exclusively by professionally-trained people with the title of "mental nurse." The mental nurse is a product of the educational system of the mental hospital. Her educational background is quite similar to the nurse trained in the schools of nursing of the New York State Department of Mental Hygiene with the exception that all of the training is done in the hospital, and an emphasis is placed upon on-the-job training more than on didactic classroom work. It is my impression that these professionally trained mental nurses are well qualified to care for the mentally ill and contribute greatly to the therapeutic atmosphere of the British mental hospital. As a general rule, the mental nurse finds his or her life's work in the mental hospital with the result that there is very little turnover of ward personnel.

I feel that in those areas visited by us, tremendous progress is being made in the care of the mentally ill. Many of these steps have already been contemplated or instituted in our own state. I would not want to conjecture as to how far we will be able to go in the future development of a community-oriented mental health program, but I, for one, am ready to support with enthusiasm those changes which the department considers adaptable to our own system.—FRANCIS J. O'NEILL, M.D.

CARE AND TREATMENT

About 40 patients occupy 15 beds every 24 hours on an ingenious shift schedule instituted by Montreal General Hospital's psychiatric unit. These day and night patients receive various therapies, including electroshock and insulin, and participate in the standard activities of the modern mental hospital.

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The number of practicing U. S. psychiatrists jumped 57%—from 5,534 to 8,713—between 1950 and 1956, the National Association for Mental Health and the American Psychiatric Association reported May 28. Even with the increase there was only one psychiatrist for every 19,200 citizens.

The nation's largest municipality has more of everything—including mental health problems. They are inevitable when growth in population far outstrips growth in social services, says Dr. Paul V. Lemkau.

He has returned to the faculty of Johns Hopkins University after a 2-year term as director of New York City's Community Mental Health Board. His successor is Dr. Maurice H. Greenhill, formerly chairman of the department of psychiatry at the University of Miami School of Medicine.

Dr. Lemkau said the CMHB is making "the first full-blown attempt to relate services for psychiatric patients to the social setting in which they live." It is responsible for improving and expanding community mental health resources, particularly mental hygiene clinics, psychiatric wards of general hospitals, rehabilitation services for patients recovering from mental illness, consultation services for schools, courts, health departments and social agencies, and educational services for parents and for professional health and welfare workers.

He reported the board had worked out new procedures making possible speedier and more humane commitment of mental patients to state hospitals from local institutions, bringing patients more quickly to treatment centers, reducing crowding in psychiatric wards, and freeing hospital beds for mental patients requiring only short-term treatment.

His successor will have some tough problems to solve, Dr. Lemkau said. They include public education, establishment of psychiatric services for courts, and care for the "problem family."

TRAINING

How psychiatric nursing is taught—and how it ought to be taught—in undergraduate programs in collegiate schools of nursing is the subject of a study launched by the National League for Nursing. Leaders in the project, first of its kind, emphasize that radical changes in methods of patient care, medical education and psychiatric aide training have spurred this effort to review basic nurse training.

Initiated with a grant of $12,420 from the National Institute of Mental Health, the 2½-year project will cost close to $100,000. Projected are five regional conferences and a summary national conference of experts in psychiatric nursing education. Their findings will be published in a report now scheduled for 1959.

Miss Anna Fillmore, NLN general director, noted that new methods of care—such as day care and follow-up care at home, use of new drugs and new emphasis on the prevention of mental illness—have prompted a reexamination of nursing education. Scientific and medical advances in which psychiatry's role is steadily increasing also are to be taken into account in reviewing nursing curricula. In addition, as more psychiatric aides, who represent the overwhelming majority of those giving nursing care to the mentally ill, are trained in the basic concepts of psychiatric care, nurses must be trained more intensively if they are to be effective nursing team leaders, Miss Fillmore pointed out.

The study will also stress the mental health aspects of nursing care for nonpsychiatric patients. The nurse who is properly trained to recognize the psychological difficulties of the patient whose ailment is basically physical can be of important aid during illness, Miss Fillmore emphasized.

Participating in the study conferences will be a wide cross-section of psychiatric nurse specialists, social scientists, psychiatric nurse educators and nurse specialists in all clinical areas of the undergraduate curriculum.

To meet the growing need for industrial psychiatrists in major industrial firms the Carnegie Corporation of New York is subsidizing 2-year Cornell fellowships. Students who qualify will spend one academic year in residence at Cornell's New York State School of Industrial and Labor Relations, taking courses in industrial human relations, personnel problems and preventive mental health programs. During the second year they will intern in selected businesses or industrial firms.

The training, approved as a 1-year residency in psychiatry, prepares graduates for psychiatric careers both in industries and universities.

The stipend is $5,250 for the first year and, with satisfactory performance, $5,750 for the second year. To be eligible, applicants must have completed a minimum of 2 years' residency in psychiatry.

* * *

The first group of 44 nurses to complete their training under the employment-education program of the Illinois welfare department have entered the mental health service and received assignments to 9 state mental hospitals and 2 state schools for the mentally retarded.

* * *

A recent survey by the Joint Information Service sponsored by the National Association for Mental Health and the American Psychiatric Association showed that over 2,050 physicians are now in psychiatric residency training—838 in the first year, 739 in the second, 492 in the third—in the 275 training centers throughout the country.

* * *

The American Medical Association and the American Board of Psychiatry and Neurology have approved Embreeville (Pa.) State Hospital for two years of training for psychiatric residents. The hospital, one of 17 operated by the Pennsylvania Department of Welfare, was previously approved for one year of training.

* * *

Three week-long workshops for clergymen of all faiths were sponsored last summer by the Institute for Mental Health of St. John's University, Collegeville, Minn. The theme of each was "Pastoral Care and Psychotherapy" and each set out to delineate what psychiatry, psychology and social work can contribute to mental health education for clergymen.

The Minnesota Association for Mental Health, endorsing similar St. John's workshops last year, pointed out that they improve a clergyman's understanding of the significance of early personality development in neurotic behavior and increase his skill in recognizing symptoms indicating a parishioner's need for psychiatric help.

* * *

PACE is the short name of a new Patient Activities Center for Education set up by the Pennsylvania Department of Welfare at Norristown State Hospital. Its aim is to train activity aides employed in the state's mental hospitals. The first class of 20 began May 6. Trainees are selected on the basis of their present proficiency and their potentials for further development. Successful completion of the training course is a requirement for promotion.

The students will be in training 4 months. They will then go back to the hospitals for 6 months on the job, after which they will return to the center for 4 more weeks of training.

The American Psychiatric Association has announced the awarding of 14 Smith, Kline & French Foundation fellowships in psychiatry. They range from a grant to the Montana State Hospital for the establishment of a training program for the hospital's psychiatric staff to a number of smaller grants that will enable medical students to participate in psychiatric programs during their summer vacations.

The grants total $38,454 and represent the largest amount given in one year under the SKF Foundation's total grant of $90,000 for the three years from 1955 through 1957. The foundation is the independent philanthropic arm of Smith, Kline & French Laboratories, Philadelphia pharmaceutical manufacturers. The fellowships are administered by a committee named by the APA.

APPOINTMENTS

The appointment of Dr. Gunnar Dybwad as executive director of the National Association for Retarded Children has been announced. He was formerly director of the Child Study Association of America.

For eight years Dr. Dybwad was director of child welfare for Michigan. He is a fellow of the American Association on Mental Deficiency and of the American Orthopsychiatric Association.

* * *

Mrs. Katherine Brownell Oettinger was sworn in May 17 as chief of the Children's Bureau in the U. S. Department of Health, Education, and Welfare. She was appointed by President Eisenhower March 25 to succeed Dr. Martha M. Eliot, who resigned January 1.

Mrs. Oettinger has had extensive training and experience in the fields of mental health, social welfare and community service. Since 1954 she has been dean of the School of Social Work of Boston University. From 1950 to 1954 she served as chief of the division of community service in the Bureau of Mental Health of the Pennsylvania Department of Welfare. During that time she also helped develop advanced studies in community organization at the University of Pittsburgh. Before that, she was a psychiatric social worker at a children's center in Scranton, Pa., and for many years was consultant to the Visiting Nurse Association of Scranton. Earlier in her career she was employed in child guidance and family welfare work in New York City.

Mrs. Oettinger is a member of the National Association of Social Workers, the National Conference of Social Welfare and the Council on Social Work Education.

REHABILITATION

A novel experiment in return to normal living for recovering mental patients is underway at Leech Farm Road Veterans Administration Hospital, Pittsburgh. Dr. Lee G. Sewall, hospital manager, termed PDQ—for Patient Discharge Quarters—the first plan of its kind tried in the nation to condition psychiatric patients for the transition from long-term hospitalization to life outside the hospital.

PDQ sets aside a hospital ward for patients who have passed the acute stage of their illness but need from 2 to 6 months' further hospitalization, Dr. Sewall said. The ward is staffed by one hospital official, Dr. John F. Muldoon, a counseling psychologist. He serves as liaison between the approximately 30 patients in PDQ and the hospital staff.

Dr. Muldoon said that as a new departure in mental rehabilitation PDQ is providing a basis for a research study of this kind of way-station in a mental hospital. The

group atmosphere that fosters "in-group" feelings has given encouraging results, he said. Many of the patients work in town and use the ward as a home. Others work in the hospital, not with patients but with the hospital staff. They care for their own rooms, take their medicine without supervision, get their money at the end of the week and spend it as they see fit.

Dr. Muldoon said the patients hold a meeting once a week and elect a council of five once a month. The recipient of the most votes serves as chairman. The ward is governed through the council, which deals with regulations, recreation and discipline.

"About the only things patients don't handle are medical problems," Dr. Muldoon said. "Other than that, they run the whole show."

* * *

The National Institute of Mental Health recently made available to all radio stations a 4½-minute tape recording of a short, inspiring talk by Dr. Robert H. Felix, NIMH director, titled "The Healing Community." Dr. Felix tells of a town in Belgium known for centuries as a haven of healing for the mentally ill—and of what is being done and could be done by American communities to rehabilitate their own victims of mental illness. He relates how an old man, typical of the thousands now living out their lives in state mental hospitals, came to live happily during his last years in a "healing community." Dr. Felix stresses the importance of foster home care to such a patient, able to leave the mental hospital but with no home to return to.

* * *

Calling attention to Mental Health Week as an unparalleled opportunity for public education about the plight of the mentally ill, the American Legion stressed that 60,000 veterans are in mental hospitals. Some 10,000 can't return home, said the Legion, because friends and families refuse to accept them.

* * *

The critics have acclaimed "Fear Strikes Out," Paramount Pictures' true-life story of Jimmy Piersall's triumphal return to big-league baseball after a bout with mental illness. Anthony Perkins, rising young Hollywood actor, portrays Piersall, star center-fielder for the Boston Red Sox. Widely-read *Time* magazine praised the movie at some length.

MEETINGS

U. S. psychiatrists have paid high tribute to the National Association for Mental Health in a warmly worded open letter hailing it as "a bastion of support for the profession of psychiatry." The letter, read at the American Psychiatric Association's annual meeting in Chicago in May by Dr. Francis J. Braceland, APA president, follows:

"We, the members of the American Psychiatric Association, take this occasion, our 113th annual meeting, to pay tribute to the National Association for Mental Health.

"Had your association done none other than provide a platform for Dr. George S. Stevenson, your medical director for many years and now your national and international consultant and the esteemed past president of our own association, you should have performed yeoman service to psychiatry and mental health. Who can claim greater status as a founding father of the modern mental health movement?

"Working alone for many years, with

small purse and in a climate of opinion that would have the mentally ill out of sight and out of mind, the National Association for Mental Health labored long and diligently to enlighten the public about the nature of mental illness and health. Its success has been of prime importance in bringing us to the threshold of a promising new day in the history of the mentally ill in America.

"The National Association for Mental Health pioneered in encouraging the development and establishment of mental health clinics for children and adults, of which there are now over 1,200 in the nation.

"It played a critical role in rallying the support that led to the establishment of the National Institute of Mental Health, whose program today is a major underpinning of psychiatric education, research and community services.

"Your association was among the early contributors to the encouragement of psychiatric education in medical schools, virtually all of which today have departments of psychiatry.

"The National Association for Mental Health has always sustained the hue and cry for psychiatric research and has wisely administered funds for research, particularly into the most challenging of all the mental illnesses, schizophrenia.

"The support of your association has helped to make possible the inspection and rating of American mental hospitals, thereby giving citizens a measure of the deficiencies of these institutions and a sound professional basis on which to correct them.

"Now your association is entering on a new and challenging program in which you propose to build a strong network of community organizations across the nation and to provide vastly more direct services to the mentally ill and their families.

"Your good works are plainly evident for all to see; but the credit lines are too often overlooked. We therefore address this special praise to the National Association for Mental Health for its past accomplishments and wish it godspeed in executing its promising programs. We hail your association as a bastion of support for the profession of psychiatry.

"Will you kindly convey this gesture of good will to the officers of the National Association for Mental Health, to Dr. Stevenson, to Mr. Richard Swigart, the executive director, and his staff, and to all those who serve it in advisory capacities."

The program for the meeting listed 132 scientific papers on psychoanalysis, psychiatry and religion, psychotherapy, mental hospitals, aging, research, health insurance and mental illness, international psychiatry, nosology, drugs, medical education, schizophrenia, psychiatry in Veterans Administration hospitals, follow-up and prognosis, private practice, military psychiatry, experimental studies, academic education, legal psychiatry, rehabilitation, sociological studies, clinical psychiatry, community mental health, and psychosomatic illnesses. At 30 round-table meetings leaders in the various fields discussed current questions.

Dr. Gregory Zilboorg, New York City, gave the academic lecture on the life and works of Dr. Eugen Bleuler, and Dr. Stig Akerfeldt of the Nobel Institute in Stockholm presented a special Adolph Meyer research lecture on his experimental blood test for mental illness.

* * *

Psychologists and educators honored the memory of one of their most admired colleagues April 13 at Stanford University

with a conference on the gifted child. It was dedicated to the late Lewis M. Terman, whose voluminous research and writings influenced the world's education, reading and marital happiness. The famed Stanford psychologist died last December at the age of 79.

Of the legacy of epochal studies Professor Terman bequeathed to the world, his personal favorite was the famous 36-year investigation of gifted children with IQ's of 140 or above. A report on the present status of this research was presented at the recent conference by Mrs. Melito Oden, an associate in the study for more than 30 years.

Of those studied in this investigation, "close to 90% entered college and about 70% were graduated," Mrs. Oden reported. "About 40% were graduated with honors and approximately two-thirds took post-graduate work. But good as these records are, the fact remains that although all were potentially superior college material, more than 10% never entered college and 30% did not graduate. In a few cases college attendance was prevented by the necessity for helping to support the family. In many more cases the high schools either failed to recognize the gifted student's potentialities or failed to give the needed encouragement and intellectual stimulation."

The study began in 1921 when Professor Terman and his assistants canvassed nearly 250,000 public school students to locate 1,528 with an IQ of 140 or above, the top 1% of the school population. Of those living, 98% are still cooperating in the study. By 1956, 104 had died. The investigators have lost track of only 30.

"Now we are able to give a fairly good picture of the gifted at mid-life," Mrs. Oden said. "Their average age is close to 45, and for the most part they enjoy good health. As to the question of how their intelligence holds up, our tests show that 30 years after their selection as gifted children the group still fell in the top 1 or 2%."

In a comparison of the 150 most successful and 150 least successful men, Mrs. Oden said, the greatest contrast was in drive to achieve and in all-around mental and social adjustment. They differed most widely in four traits: persistence in accomplishment of ends, integration toward goals, self-confidence, and freedom from inferiority feelings.

"When asked to indicate from a list of ten factors those which had contributed most to their life accomplishment, both men and women put 'adequate education' in first place and 'mental stability' second," Mrs. Oden reported.

Regarding sources of satisfaction, three-fourths of the men ranked their work first, but less than half the women did so. Marriage and children were the women's first choice, followed by social contacts, hobbies and community service activities. The men's secondary sources of satisfaction were marriage and children, recognition of their accomplishments, and hobbies—in that order.

As to their opinions of what constitutes success in life, men most often recommended a happy home, adequate income for comfortable living, and making a contribution to society. Women, said Mrs. Oden, give as their most frequent definition of success in life the making of a contribution to society and doing something positive to improve the world. Almost as frequent was the definition of a happy home, followed by realization of goals.

The fifth volume of the Terman study of gifted children has been scheduled for publication this year. He also developed the Stanford-Binet intelligence test. Translated

into more than 20 languages, it became the standard against which all other proposed intelligence tests are measured.

* * *

Increasing shortages of skilled psychiatric manpower were predicted at the Northeast State Governments Conference on Mental Health April 25 in Hershey, Pa.

The whole future of mental health services of all types and the continued protection and improvement of the mental health of the American people are jeopardized by the rapidly increasing gap between the number of available mental health personnel and the needs, T. P. Wuichet, executive assistant to the director of the Ohio Department of Mental Hygiene and Correction, told the conference.

Dr. Robert A. Matthews, commissioner of mental health in the Pennsylvania Department of Welfare, summing up his state's critical need for psychiatrists, psychologists, social workers and patients' activities workers, answered the question, "Where do they come from?" in this way:

"Some are now available—if we make their work and pay interesting enough to get and keep them.

"We steal some from other states—let's be frank—with the inducements mentioned above.

"We train some—quite a lot—and we will be training more.

"We educate the community to be a therapeutic unit of society—to create institutions and environments conducive to good mental health.

"We must be prepared to accept, for a while, exorbitant demands on our time and services. But we can console ourselves with the indisputable fact that mental health, throughout the nation, is on the march. The people are demanding that their mental health needs be met. And slowly but surely they are finding the ways and means of meeting these needs."

* * *

The First Caribbean Conference on Mental Health organized by the Aruba Society for Mental Health convened March 14–19 in Aruba, Netherlands Antilles. Dr. J. R. Rees, director of the World Federation for Mental Health, served as conference chairman. The theme was "Constructive Mental Hygiene in the Caribbean."

The conference opened Thursday morning, March 14, with an address by His Excellency Dr. F. J. van der Valk, acting governor of the Netherlands Antilles, who served as honorary chairman. The Honorable Dr. L. C. Kwartsz, lieutenant governor of the island territory of Aruba, and J. H. Beaujon, cultureel centrum Aruba, greeted delegates, government officials, civic and business leaders and members of the Aruba Society for Mental Health in attendance. His Excellency, Msgr. J. Holterman, apostolic vicar of the Netherlands Antilles, also briefly addressed the conference. The opening session concluded with an invited paper, "The Importance of Mental Health," by Dr. C. van den Berg, director-general of international health affairs, The Hague.

In the afternoon and evening of the first day the conference "got down to business" with a round-table discussion of mental health problems found in each of the geographical areas represented. This discussion anticipated many of the later sessions since problems of alcoholism, home, family and school life, and the impact of industrialization on local cultures were reported by most delegates. Mr. and Mrs. Irving Jacoby brought this session to a close with a showing of several Mental Health Film Board films.

The sessions on March 15 were devoted to alcoholism as a mental health problem. Papers by Mrs. Dorothy M. Johnson and Mrs. Marian Kalashian of the Florida Alcoholic Rehabilitation Program and a report by Miss L. Berkley, social worker in the Aruba Department of Social Affairs, on the alcohol problem in Aruba touched off an extended discussion. There was general agreement as to the serious nature of this problem among Caribbean island peoples although it was recognized that alcoholism as such is probably just one of many symptoms of more fundamental social problems growing out of major cultural change. Delegates finished this day by attending an open meeting of the Aruba chapter of AA.

Saturday morning was given over to examining home, family and school problems. Mrs. E. B. Hansen, acting director of mental health services for the U. S. Virgin Islands, reported on the special demonstration-teaching project underway with slow learning children. Miss Elsa Haglund, home economics officer for FAO in Rome, who is on loan to the Caribbean Commission in Trinidad, spoke on "Education for Home and Family Living." This paper was of particular interest to the delegates since Miss Haglund drew on her long experience in the field to illustrate ways in which the family group could be strengthened through improvements in physical living arrangements, better housekeeping and adequate and nutritious foods. The discussion following these papers brought out the inappropriateness of much of the education given children in various island schools. Textbooks, for example, are either European or North American and do not relate to the Caribbean scene. Teachers are either foreign, that is, from the mother country, or have received all or part of their pedagogical training there. The language of instruction may not be the language spoken at home. And there is little being done by way of instruction in either the fine arts or the practical arts. Although much thought and study are being given to these problems it may be some years before suitable school systems are developed for the Caribbean.

A public meeting on Saturday evening featured a panel discussion of "Mental Health in Public Health" with Mrs. Dolores G. LaCaro, director of the Mental Health Bureau of Puerto Rico as chairman. Dr. B. Caravedo, director of the Department of Mental Hygiene in Lima, Peru, Miss Ixia Sifontes, health educator for Puerto Rico, Dr. Rees and Dr. van den Berg served as speakers. In his presentation of the problems encountered in dealing with the mental health of the large Peruvian Indian population Dr. Caravedo illustrated very clearly the tremendous task facing individuals and organizations working in the areas of the world which are undergoing cultural, social and economic change.

Sunday was a free day for delegates during which they were entertained at a barbecue, taken on island tours and otherwise given a chance to relax in Aruba's famous sunshine and gentle breezes.

The conference resumed on Monday in the general offices of the Lago Oil and Transport Company, Ltd., a Standard Oil Company (NJ) subsidiary, for a meeting with company executives on the problems of industrial mental hygiene. Dr. van den Berg spoke on approaches in industry currently utilized in the Netherlands. Dr. Bertram Schaffner, consultant to the United Nations secretariat, presented a paper summarizing preliminary findings from the current investigation of the mental health problems of U. S. citizens overseas. This research report was of special significance to

company officers inasmuch as Lago has about 550 U. S. expatriate employees ond their families. Dr. Rees closed this meeting with comments on management's role in worker satisfaction and morale.

The final public meeting, held Monday evening, was devoted to a panel discussion titled "What Is Mental Health?" The first description, given in a philosophical vein, was presented by Dr. A. Poslavsky, professor of medical psychology at the University of Utrecht, Holland. Dr. Schaffner then spoke of mental health in terms of child development. Dr. Eric O'Neil, commissioner of health for the U. S. Virgin Islands, described mental health by means of an outline of a community program. Dr. Rees concluded by stating some of the aims of the World Federation for Mental Health and telling of its work.

The Tuesday session was given over to a series of short reports. Dr. R. M. Lloyd-Still, psychiatrist-in-charge at Barbados, described the open hospital plan which he has successfully developed. Dr. E. R. Henry, chief psychologist for the Standard Oil Company (NJ), reported on research in attitudes and on problems of communicating research findings to administrators. Dr. M. Despinoy spoke on his observations of schizophrenic patients in Martinique.

At an earlier meeting, a committee under the chairmanship of Dr. L. F. E. Lewis, St. Ann's Hospital, Trinidad, had been appointed to study the feasibility of forming a Caribbean Federation for Mental Health. The conference adopted the committee's report favoring the establishment of an interim steering committee pending a Second Caribbean Conference in the Virgin Islands in 1959.

The concluding session on Tuesday evening was highlighted by a conference evaluation prepared by Dr. Schaffner. A series of resolutions were also adopted by the delegates.

Conference proceedings, which are now being prepared, will be published in the fall of 1957 through a grant from the Prins Bernhard Fund. Copies will be available at a nominal charge from the Aruba Society for Mental Health.

Officers of the Aruba Society for Mental Health, which made the conference possible, are Dr. Robert Turfboer, chairman; Dr. W. E. Kendall, vice-chairman; T. F. Hagerty, treasurer; M. Croes, first secretary; Rev. D. Evans, second secretary; Judge J. Schaafsma and Father J. A. N. Burgemeester, members-at-large.

* * *

The Second International Congress of Group Psychotherapy convened August 28–31 in Zurich. Plenary sessions, section meetings, workshops and small discussion groups reflected the many applications of group psychotherapy—in a variety of settings and in different countries—to different types of clinical problems, as well as its broader community and interdisciplinary implications for clinical psychiatry, social psychiatry, psychoanalysis, psychodrama, research, industry, education, social prophylaxis and training.

Special emphasis was laid on the use of group psychotherapy with children, adolescents, non-psychotic and psychotic adults, and on special problems in such settings as in-patient hospitals and out-patient clinics. Acting-out in group psychotherapy received special attention in a section meeting.

The congress is under the auspices of the International Committee of Group Psychotherapy, which has representatives from 17 countries. Its officers include J. L. Moreno, S. R. Slavson, W. Hulse and W. J. Warner of

the U.S.A., J. Bierer of the UK and S. Lebovici of France, presidents; N. Beckenstein and R. J. Corsini of the U.S.A., H. Ezriel, S. H. Foulkes and T. P. Rees of the UK, Georges Heuyer of France, Hans Hoff of Austria, L. J. Hut of The Netherlands, E. E. Krapf of Argentina, K. R. Masani of India, Frisso Potts of Cuba, E. J. Rosen of Canada, C. A. Seguin of Peru, A. Sunier of The Netherlands and Nic Waal of Norway, vice-presidents.

PUBLIC INFORMATION

Two programs on mental illness and mental retardation have won for the public affairs department of the Columbia Broadcasting System and WCBS-TV a medical journalism award from the Albert and Mary Lasker Foundation. The prize-winning programs were the epochal "Out of Darkness" and "The Wassaic Story."

"Out of Darkness," a landmark in public education about mental illness, was produced in consultation with the National Association for Mental Health and the American Psychiatric Association. The CBS-TV network presented it for coast-to-coast audiences three times last year, and prints have since been screened by mental health associations and other civic groups all over the country.

Roland H. Berg, medical and science editor of *Look* magazine, also won a Lasker award for a summary of the nation's health published in an April issue last year. In discussing the problem of mental illness, he pointed out: "It is estimated that it would cost nearly $150,000,000 merely to train the additional professional people needed to give minimum standards of treatment."

Benjamin Franklin magazine awards went to John Bartlow Martin for his *Saturday Evening Post* series called "Inside the Asylum," which appeared from October 6 through November 10, and Gladys Denny Shultz for her *Ladies' Home Journal* article in June 1956 on the mentally defective and retarded child.

* * *

A new film (black and white, sound, 35mm) called "A Comprehensive Treatment Program in Mental Retardation" has been completed at Pineland Hospital and is now available for nationwide distribution. Interested professional groups, mental health associations and legislative bodies should contact the Director of Research, Pineland Hospital and Training Center, P. O. Box C, Pownal, Me.

* * *

The National Association for Mental Health has produced a film designed to show lay audiences that fear, stigma and lack of public understanding are preventing the discharge of many mental hospital patients. Grants totaling $19,000 from Sigma Beta sorority made possible the film's production and the purchase of prints for use by state and local mental health associations and other community organizations. The premiere will take place this month in Indiana under the joint auspices of Sigma Beta, the Indiana Association for Mental Health and the NAMH.

* * *

The American Psychiatric Association is producing a public education film on the psychiatrist and his work.

PUBLICATIONS

In breaking a path for others to follow, the pioneer inevitably works himself out of a job as newcomers begin to cultivate the ground he first trod. That is now the fate of *Understanding the Child,* 27-year-old quarterly journal for teachers. It will cease

publication with the October issue, officials of the National Association for Mental Health have announced.

For many years the magazine pioneered in providing educators with a better understanding of mental health principles. It blazed the trail with such marked success that now at least seven periodicals stress the role of the schools in mental health. In recent years many articles of interest to teachers have appeared in MENTAL HYGIENE.

Dr. W. Carson Ryan of Chapel Hill, N. C., long-time editor of *Understanding the Child,* will continue to serve NAMH in a new capacity as consultant on mental health education in the schools. He will officially represent the association at conferences of key educational groups and will continue to stimulate the publication by educational journals of articles about mental health.

* * *

The volunteer is the subject of a new pamphlet published by the Adult Education Association of America.

Working with Volunteers approaches the topic from several angles—from the standpoint of the professional staff member who works with and supervises volunteers, from that of the volunteer whose recruitment and training for a particular job give personal satisfaction, from that of the recruiting agency and its responsibilities to those who volunteer and from that of the volunteer who supervises other volunteers.

Of particular interest is the pamphlet's reference to the justly renowned education program of the St. Louis Mental Health Association. And of paramount value is the section on the role of the recruiting agency and the three sections on placement, training and supervision.

Though the pamphlet's authors represent other agencies, the principles they enunciate are applicable, with appropriate modifications, to the volunteer services of mental health associations.

Working with Volunteers is available from the National Association for Mental Health for 60¢ a copy, with special rates for quantity orders.

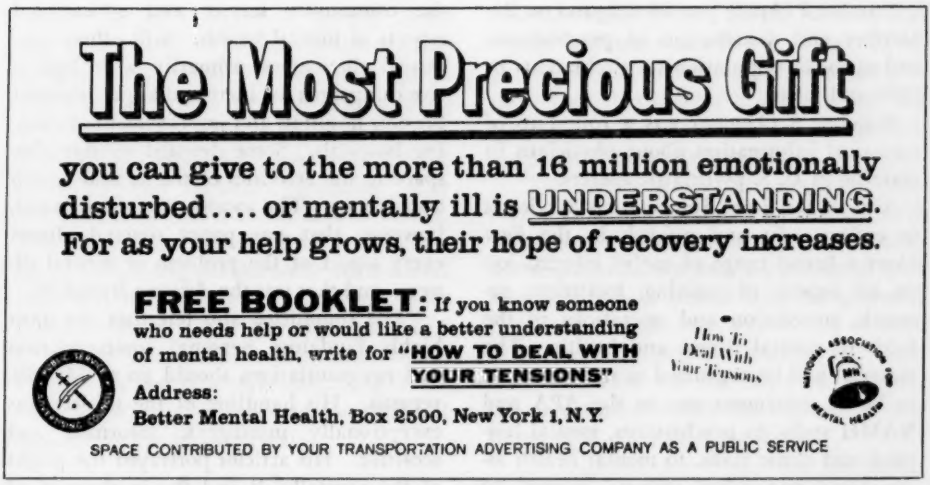
* * *

A single announcement of a new booklet about emotional tensions brought requests for almost 140,000 copies in three weeks. Many hundreds of thousands will be distributed this year, according to present estimates.

The booklet, "How to Deal with Your Tensions," is part of a year-round public information campaign sponsored by the Advertising Council on behalf of the National Association for Mental Health. It was written by Dr. George S. Stevenson, NAMH consultant, in collaboration with Harry Milt, public information director.

The first announcement of the booklet appeared May 19 in *This Week,* Sunday magazine distributed by major newspapers throughout the country. News stories about it began appearing June 10. These plus subsequent TV, radio, transit, newspaper and house magazine advertisements will result in a deluge of requests for the booklet, its sponsors foresee.

Free single copies now are offered streetcar, bus and subway riders through car cards posted as a public service by national transportation advertising companies. Starting late in June, newspapers cooperating with the Advertising Council began to publish advertisements suggesting that readers write for "How to Deal with Your Tensions." Throughout the summer, local radio and television stations, networks and many of the commercially sponsored network programs joined in the campaign. At the same time, house magazines pub-



This ad is appearing in buses, streetcars and subways throughout the country.

lished by some of the leading corporations cooperated by suggesting that their employees obtain the booklet for their personal guidance.

The booklet is sent to anyone writing to Better Mental Health, Box 2500, New York 1. Quantity lots will be sold at cost to industries and organizations wishing to distribute the booklet to employees or members.

Although distribution of the booklet is an Advertising Council project, the National Association for Mental Health is bearing the cost of printing and distributing it. A $15,000 grant to NAMH from the Smith, Kline and French Foundation of Philadelphia helped to underwrite the first printing.

Primary objective of the campaign, according to the Advertising Council, is to help contribute to the public's understanding that mental illness and emotional disturbance, while top U. S. health problems, are:

- Being dealt with more effectively than ever before.
- Are illnesses like other illnesses, with no stigma attached.
- Can be brought under still better control and with quicker cures through better understanding by citizens and through more active support of organizations and groups working for the better mental health of all.

• • •

A new publication providing statistics on various aspects of the nation's #1 health problem—mental illness—has made its appearance. It is the *Fact Sheet* of the Joint Information Service sponsored by the American Psychiatric Association and the National Association for Mental Health.

Number 1 (March) contained an analysis of patient-employee ratios in public mental hospitals in all states from 1939 to 1955 and a series of tables on mental hospital expenditures, personnel inadequacies and the admission and discharge of patients.

Number 2 (April) provided figures on the number and distribution of psychiatrists, and ratios of population to psychiatrists in 1950 and 1956.

Number 3 (August) was a round-up of statistical information about physicians in training in U. S. psychiatric centers.

Aim of the Joint Information Service is to collect, edit and publish in the *Fact Sheet* a broad range of useful information on all aspects of training, treatment, research, prevention and operations in the fields of mental illness and health. The material will be organized in such a way as to be of maximum use to the APA and NAMH staffs, to psychiatrists, mental hospital and clinic staffs, to mental health associations and other citizens' groups, to public officials, legislators and others.

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The *Arizona Republic* received the National Mental Health Bell Award for 1956 in ceremonies May 2 at the Arizona State Hospital. The award is given each year by the National Association for Mental Health to an American daily newspaper which during the preceding year makes an outstanding contribution to the fight against mental illness. The award consists of a bronze facsimile of the Mental Health Bell mounted on a walnut plaque.

Special tribute was paid to reporter Ronald Silverman, whose notable series of articles on the hospital played considerable part in the newspaper's achievement. Mrs. M. E. Harris, Jr., of Salt Lake City, NAMH regional vice-president who presented both honors, said: "The award committee found the selection of a single newspaper a very difficult task because of the excellence of most entries. Coverage was amazing—both as to quality and quantity. Some entries stressed the crusade for better mental hospital conditions. Others concentrated on the community service and educational aspects of mental health. Still others concerned themselves primarily with legislative campaigns for increased appropriations for new hospitals and improvement of existing hospitals. Some devoted considerable space to the activities of the mental health associations. The award committee found, however, that one paper covered almost every aspect of the problem of mental illness—and that was the *Arizona Republic.*

"The committee also felt that the most highly laudatory personal commendation and congratulations should go to Mr. Silverman. His handling of the subject was exceptionally intelligent, informed and sensitive. His articles portrayed the plight of the mentally ill and the inadequacy of mental hospitals without resorting to sensationalism, name-calling or finger-pointing. The educational value of his series was immense. We are certain that as a result of the coverage by the *Arizona Republic* and particularly as a result of Mr. Silverman's work the people of Phoenix have a much better understanding of and sympathy for the plight of the mentally ill and the problem of mental illness in general," Mrs. Harris observed.

Previous winners of the award have been the Austin (Texas) *American Statesman,* 1956; *Indianapolis Times,* 1955; *Hartford Courant,* 1954, and *Baltimore Sunpapers,* 1953, first year of the award.

Factors considered in selecting the award-winning newspaper included dissemination to the public of mental health news, information and opinion; publicizing and editorial support of local, state and national mental health programs, objectives and fund drives; leadership in campaigns to secure new or improved mental health services for the prevention and treatment of mental illness and the advancement of good mental health.

Interest in the problem of mental illness and in the work of mental health associations is being stimulated among clergymen and leading laymen with the distribution of several thousand special packets compiled by the Council for Social Action of the Congregational Christian Churches. The packets include *Facts about Mental Illness, The Clergy and Mental Health, Ministering to Families of the Mentally Ill, Pastoral Help in Serious Mental Illness, What Every Child Needs for Good Mental Health, List of Mental Health Publications and Audio-Visual Aids* and brochures describing *Notes for After 50*—all published by the National Association for Mental Health.

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A Psychiatric Glossary has been published by the American Psychiatric Association's committee on public information. The attractive 56-page booklet defines in nontechnical language the 500 words most frequently used in psychiatry.

Mental health associations, writers and editors, lawyers, clergymen, health and welfare workers will find it helpful. The APA hopes it will be specifically useful to premedical and medical students and that it will help in introducing students of psychology, nursing and social work to psychiatric terminology.

The glossary is available from the National Association for Mental Health, 10 Columbus Circle, New York 19, for $1 a copy, with special rates for quantity orders.

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A strongly optimistic note on the prospects for continued success in the fight against mental illness was sounded by the National Association for Mental Health in its annual report released recently. F. Barry Ryan, Jr., president of the organization, said in the report that mental hospital figures for the last year bore out the belief that a turning point has been reached.

"This belief was borne out quite dramatically by the year-end figures for 1956 which showed that in state and county mental hospitals (which care for about 90% of all the nation's mental hospital patients) there had actually been a reduction of some 7,000 resident patients during the year. This, we stress, was not just a deceleration but an actual reversal—the beginning, very likely, of a downward trend."

The tranquilizing drugs, said Mr. Ryan, played a significant role in this development. But, he added, there were many other important factors, including "the extension of treatment instead of mere custody to a much larger percentage of the patients than in previous years. This means not only drug treatment but psychotherapy, shock therapy, recreational therapy, occupational therapy and other adjunctive therapies."

Mr. Ryan noted that during the year eight new state mental health associations and 50 new local mental health associations had been added to the roster of NAMH affiliates. The new state organizations were in Mississippi, Missouri, North Carolina, District of Columbia, Washington, Georgia, Wyoming and West Virginia. There are now 41 state and territorial affiliates and 510 local affiliates. The joint fund-raising efforts of the affiliates and the national headquarters realized slightly more than $3,000,000—an increase of 25% over the previous year.

A limited number of copies of the *Pineland Hospital Bulletin*—with papers on the retarded deaf and hard of hearing, rewards and punishments in a school for the mentally retarded, and a comprehensive treatment program in mental retardation—is still available for $1 each from the Treasurer, Frank D. Self Research Foundation, P. O. Box C, Pownal, Me.

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Construction of mental hospitals will soon be a thing of the past, according to the American Psychiatric Association. That is, if more up-to-date, more effective—and in the long run more inexpensive—means of dealing with community mental health problems are successfully put into use.

This is the major finding of a recently completed mental health survey conducted for Pennsylvania by the American Psychiatric Association. Pennsylvania is the fifth state in the Union to have an APA survey of its entire mental health system and problems.

A summary of the findings has been published as a booklet by Pennsylvania Mental Health, Inc., state affiliate of the National Association for Mental Health.

The idea that a hospital is the only site of psychiatric treatment, or even the most important site, is becoming outmoded, according to the booklet. "Other forces directed at preventing mental illness and thus eliminating the necessity of sending a patient to a hospital are coming to the fore. If it is necessary to send a patient to a hospital, the time he had to spend there is being cut short. This is true for almost every type of patient," the report stresses.

Pointing out that great areas of Pennsylvania have no psychiatric services at all and that most facilities are centered in the southeastern and western sections of the state, the APA recommends a series of state-wide community services which would not only catch and cure many persons in the early stages of mental illness, but would eventually release many of those now overcrowding existing mental hospitals. Though some mental hospitals will always be necessary, most mental patients aren't dangerous. Many now confined could lead useful lives in the outside world if they had the proper treatment and training and many others would not need to go to hospitals at all if given early diagnosis and help.

The key to proper treatment, says the survey, is trained personnel. The APA recommends state subsidies to Pennsylvania's medical schools for the training of psychiatrists and expansion of training plans for psychologists as well as for three times the present number of social workers.

What positive action should Pennsylvania take? First, says the report, limit the building of new hospitals except for those already authorized, until new and bolder methods are tried. Second, work out a strong Pennsylvania plan to get people out of mental hospitals and help keep them out. Proposals include:

Community mental health centers to serve as the backbone of a community's mental health activities. Here the mentally ill could be screened and sent to the proper place for treatment; patients leaving mental hospitals could be watched and helped; older people could receive recreation and emotional support; hospitals and other agencies could work closely together. Prevention as well as cure would be integral in the community center's program. Its aim would be to help people in all walks of life develop their own defenses against emotional illness.

Branch hospitals where people—such as the

elderly—who need continuing psychiatric supervision but limited services could live in a residential building away from the main hospital but still under its direction. These elderly people today occupy beds in mental hospitals that could be freed for patients needing all of the hospital's psychiatric facilities.

Day hospitals where patients could receive the benefits of hospital treatment and activity during the day and return to the warmth and security of family life in the evening.

Night hospitals where those who are able to work during the day could come to sleep and receive the same kind of intensive treatment and care at night that their counterparts receive in a day hospital. Ideally, one building could be used for both day and night hospitals, thereby doubling its use.

Half-way houses located away from hospitals where those going into mental hospitals could get used to the idea and gain a better understanding of their illness (possibly even become cured to the extent that hospitalization would be unnecessary) and where those coming back out of mental hospitals could ease their adjustment to a life in the community.

Foster homes where a competent housewife or couple would care for mental patients, including retarded children, who have no other place to go, thereby helping some communities which have no facilities.

Other suggestions include the development of psychiatric divisions and rehabilitation services in general hospitals, sheltered workshops, and diagnostic and screening centers to speed the flow of patients toward the right treatment and cure.

"These new ideas," sums up the report, "make it possible to help people in emotional difficulty in the earliest stages of their illness, when they are most apt to respond to treatment. They bring the care and treatment closer to home, where it is easier to get. They make the most of what the community can do best. They galvanize the goodwill of those who want to help others and turn it into a healing process."

The booklet is available from Pennsylvania Mental Health, Inc., 1 N. 13th St., Philadelphia 7.

AWARDS

A record number of 130 mental hospital ward attendants have been named by the National Association for Mental Health as winners of its Psychiatric Aide Achievement Awards for 1956. The recipients—67 women and 63 men—were selected from almost 47,000 psychiatric aides who provide direct services to more than 300,000 patients. They were nominated by coworkers, patients and visitors as most representative of the higher quality of care given to patients during the past year by ward personnel.

Each winner received a gold pin and a certificate of achievement at a public ceremony during Mental Health Week. This year's presentations marked the 10th anniversary of this program, designed to focus attention on the important role played by the psychiatric aides in the treatment and care of the mentally ill.

Participating were 130 state, VA or other federal hospitals for the mentally ill and mentally handicapped in 36 states and Washington, D. C. Each hospital selected its winner for his outstanding services to patients during 1956 or longer; for skill, initiative and imagination in discharging his duties; for exemplary kindness and devotion to the patients in his care, and for

citizenship displayed in his off-duty activities.

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Mrs. Marie Yegella, a teacher at New York's Wassaic State School, won recognition May 9 for her pioneering work with severely retarded children when she received the Gov. Charles E. Hughes Award in Public Administration. It is given annually by the American Society for Public Administration for significant achievements resulting in outstanding benefits or services, usually "beyond the call of duty."

GENERAL

The San Francisco Council of Churches is launching a senior citizen project to stimulate churches to set up neighborhood centers open to older adults of all faiths. A foundation grant will underwrite the project as a demonstration for 15 months. In 1958–59 it will receive United Community Fund support.

The council is training volunteers for the centers, indoctrinating them in the philosophy of working with older people, in group work techniques and in the skills of arts and crafts. The aim of the program is to appeal to older isolates and those who feel that life has passed them by, and to help them to develop new relationships.

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The institution, formerly known as the North Shore Health Resort, observed its 57th anniversary April 1.

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NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
